The Ennis Centre for pain management

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June 25, 2013

Law Firm

## PSYCHIATRIC (CHRONIC NONCANCER PAIN) EVALUATION

| | |
|---|---|
| **Patient:** | **Patient** |
| **Date of Birth:** | **xxxx/xx/xx** |
| **Date of Report:** | **June 25, 2013** |
| **Date of Loss:** | **xxxx/xx/xx** |
| **Your File No.:** | **XXXXX** |
| **Evaluator:** | **Dr. J.H. Ennis, Psychiatrist** |

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## QUALIFICATIONS:

I am a duly qualified medical practitioner licensed to practice by the College of Physicians and Surgeons of Ontario. I obtained my MSW degree at the University of Toronto in 1982, and my MD degree at McMaster University in 1988. Following my residency in psychiatry, I participated in an additional three years of supervised training in the treatment of patients with chronic non-cancer pain. I am a Consultant in Psychiatry and certified as a Fellow of the Royal College of Physicians and Surgeons of Canada in this specialty. I was an examiner for the College of Physicians and Surgeons of Ontario. I held the position Associate Director of the Chronic Pain Management Unit at Chedoke Rehabilitation Services. I was the Director of the *HSO Pain Management Group* and the *East End Multidisciplinary Pain Management Program.* Currently, I am the director of *The Ennis Centre for Pain Management,* located in Hamilton, Ontario. I hold cross appointments in the Department of Physical Medicine and Rehabilitation, and the Department of Psychiatry and Neurobehavioural Sciences. I am a part-time



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clinical Assistant Professor in the Faculty of Health Sciences at McMaster University in Hamilton, Ontario, Canada. My clinical practice is devoted to the assessment and treatment of patients with chronic non-cancer pain.

**CONSENT*:***

At the outset of the assessment I did have Patient complete a form 14 consent for disclosure of information. I also spent time with the patient reviewing the role of the expert witness. He did sign a document indicating that he understood this role. Finally, Patient did sign a document which outlines the limits of confidentiality in the context of this assessment.

The disclosure of information allows this documents to be distributed to the following:

Lawyer

Patient was seen for an independent psychiatric evaluation at the request of his legal representative. This patient has been under my care. However, I did explain to him that I would make every effort to be as unbiased as possible given that we already have a doctor-patient relationship. If a physical examination is carried out it is carried out in the presence of my secretary, Ms. XXXX. The nature of the examination was explained. Patient understood that he could stop the examination at any point for any reason. If pain was produced by any test or other aspect of the examination it should be brought to my attention and the test would be discontinued. The patient understood that he could make such a request without jeopardizing his situation.

Patient understood that I have been asked by his legal representative to provide an unbiased response to the following questions/issues:

1. **What symptoms are noted upon examination?**

2. **What are the results of the examination?**

3. **What is your diagnosis?**

4. **What, if any, contribution did the motor vehicle accident of xxxx/xx/xx have towards Patient's present condition?**

**5. This action is governed by Section 4.2 of Ontario Regulation 461/96 as amended by Ontario Regulation 381/03. I enclose a copy of this section. Could you please comment on the following:**

**(a) Whether the impairment:**

**I. substantially interferes with Patient's ability to continue on his regular or usual employment despite reasonable efforts to accommodate Patient's impairment and Patient's reasonable efforts to use the accommodation.**

**ii. substantially interferes with Patient's ability to continue training for a career, or**

**iii. substantially interferes with most of the usual activities of daily living considering Patient's age**

**in accordance with Part 1 of Section 4.2(1) 1.**

**(b) Whether the function that is impaired is an important one in accordance with Section 4.2 (1) 2 and,**

**(c) Whether the impairment is permanent within the meaning of Section 4.2 (1)3.**

**6. Your assessment of whether the current complaints or any complaints attributable to this accident, have or currently interfere or will in the future interfere with Patient's employment duties or future plans.**

**7. Your assessment of whether the current complaints have or currently interfere or will in the future interfere with Patient's ability to undertake housekeeping and home maintenance tasks.**

**8. Your assessment of any reasonable treatment required or likely to be required in the future as a result of the complaints attributable to the accident.**

**9, What is your prognosis?**

**10. What impact have the injuries from the motor vehicle accident of xxxx/xx/xx, had on Patient's past and future earning capacity and whether**

**this will have any impact on his work life expectancy?**

**11. Your assessment of whether Patient suffers a complete inability to engage in any employment or self-employments for which he is reasonably suited by education, training or experience.**

**12. Finally, I have been asked to provide a catastrophic assessment of Patient.**

Patient stated that he understood the nature of the assessment and gave his consent for it to proceed.

## SOURCE OF DATA:

***Reports:***

- Primary Care Physician Notes
- ER Report dated 19/1/86
- ER Report dated 29/03/89
- Chest X-ray dated 29/03/89
- ER Report dated 1/5/93
- Plain Film X-rays of the Spine dated 1/5/93
- ER Report dated 14/12/93
- CT of the Spine dated 4/5/94
- ER Report dated 24/6/01
- Ambulance Call Report dated April 3, 2009
- Emergency Room Cover Sheet dated 3/4/09
- Nursing Notes dated April 3, 2009
- X-rays of the Pelvis and Lumbar Spine dated April 3, 2009
- MRI of the Cervical Spine dated 30/06/09
- Neurological Report completed by Dr. XX (neurologist) dated August 11, 2009
- MRI of the Brain dated 11/09/09
- MRI of the Lumbar Spine dated September 29, 2009
- Report by XX (PT) dated September 29, 2009
- In Home Functional Assessment Report completed by XX (OT) dated November 25, 2009
- Psychological Report completed by XX (psychologist) dated February 25, 2010
- Occupational Therapy Attendant Care Progress Report completed by XX (OT) dated March 3, 2010
- Report completed by XX dated March 8, 2010
- Consultation Report completed by XX dated 13/04/10

- Report completed by XX (urologist) dated May 25, 2010
- In Home Functional Assessment Report completed by XX (OT) dated September 18, 2010
- Report completed by XX (neurosurgeon) dated September 21, 2010:
- MRI of the Lumbar Spine dated 24/09/10
- Report completed by XX (neurosurgeon) dated October 26, 2010:
- Occupational Therapy Attendant Care Progress Report completed by XX (OT) dated February 1, 2011
- Functional Abilities Evaluation completed by XX (certified functional evaluator, chiropractor) dated February 4, 2011
- Report completed by XX (neurosurgeon) dated February 15, 2011
- Job Site Analysis as a Driver of a Fat and Bone Pick Up Truck completed by XX dated March 11, 2011
- Independent Orthopedic Evaluation completed by XX (orthopedic surgeon) dated March 16, 2011
- Report by XX (psychologist) dated March 29, 2011
- Report completed by XX (social worker), XX (psychologist) dated August 17, 2011
- Physiotherapy Report by XX (physiotherapist) dated October 19, 2011
- Occupational Therapy PGAP Termination Report
- Report completed by XX (psychiatrist/pain specialist) dated December 8, 2011
- Addendum Report completed by XX (psychiatrist/pain specialist) dated December 8, 2011
- Psychological Report completed by XX (psychologist) dated December 29, 2011
- Psychiatric Assessment Report completed by XX (psychiatrist) dated February 28, 2012
- Report completed by XX (psychiatrist/pain specialist) dated June 27, 2012
- Discharge Summary Report completed by XX (psychiatrist/pain specialist) dated September 14, 2012

***Clinical Assessment:***

A clinical assessment was conducted at the Medical Arts Building in Hamilton, Ontario on June 25, 2013.

***SECTION I***

***The information contained within this section derives solely from the subjective verbal history provided by the patient.***

**IDENTIFYING DATA:**

Patient is a 47-year-old man. He has three children from his first marriage, two daughters and a son. He has been in his current relationship for twelve years although he is not legally divorced from his first wife and there is a daughter, age 10, from his current wife's previous relationship. Prior to the accident Patient drove trucks, picking up rendered material from restaurants. He would work in excess of 60-70 hours per week. Patient had a myocardial infarction in 2005 related to excessive blood loss.

Associated with the accident of XXXX/XX/XX (index MVA) Patient has had the onset of wide spread non articular pain, sad mood associated with a reduced level of function.

**HISTORY:**

Patient was driving a Dodge Pickup truck at approximately 9 o'clock in the morning in the area of Parkdale and Mead. A van made a left turn without looking and hit Patient's car on the passenger front tire pushing his vehicle across three lanes into two other parked cars. Ultimately the car was stopped by a lamp post and the patient was able to extricate himself from the vehicle but he felt dissociated.

A witness took him into her car and eventually an ambulance took him from that car, using neck precautions, to the Hamilton General Hospital. He had imaging done and was assessed and was discharged the same day. At that time he described feeling as though he had a broom stick handle being pushed through his right buttock into his leg and into the foot.

Since that time this patient has had multiple investigations and assessments. Treatment has included physiotherapy and massage therapy which he did not find helpful. He has had trials of a number of medications including Nortriptyline and Gabapentin but with each medication he generally feels unwell. He reports that the only medication that he can take without problems is Lorazepam which he was using

prior to the index accident.

Side effects from medications include severe nightmares related to Nortriptyline and mental confusion related to Gabapentin.

Patient attended the 15 week program at the XX Centre for Pain Management. He found the program very helpful. While in the program he lost weight and his level of function improved. His general outlook improved. However, after the program he found himself regressing. He had difficulty motivating himself to increase his level of activity. At the same time there were issues in his own personal life. By way of example, his oldest daughter had twins born, both of whom had encephalopathy. This put a significant amount of stress on the patient. His current hope is to be able to engage in a swimming program, exercise program and possibly hypnotherapy. He has to be cleared by his cardiologist first.

Patient had been funded to attend our aquatherapy program. However, he had some physical problems that prevented him from attending. Specifically, he developed an adult onset allergy to tree nuts. He found this out after drinking almond milk which he has used for many years. He then had to discontinue his use of beta blockers because this medication would block the efficacy of an epi-pen if required. When the beta blocker was stopped his blood pressure dropped and he began to develop a tachycardia.

*This response may well be related to his use of Ditrical. Didrocal is anticholinergic and can cause hypotension and tachyarrythmias[1].*

In response he has been assessed by cardiology and he will be seen today to review results of testing.

Other treatments have included continued involvement with Dr. XX (psychologist). In general Patient reports that he finds it helpful to get things off his chest to someone who is not a family member.

Patient also reported being involved in some type of activation program through XX. He found the program somewhat helpful. He is also seeing a urologist for incontinence. He has had a scope which did not show any evidence of pathology. According to the patient he was given Flomax and Detral as a “hail Mary” because there was nothing else to be done.

*Flomax is used in the treatment of prostatic hypertrophy. Detral is used in the treatment of urinary incontinence.*

[1] Please note: All of the author’s (Dr. Ennis) comments in regards to consultation reports will be in italics and ‘border filled’ in light grey.

***Current Symptoms: (As of June 25, 2013)***

Patient reports headaches which have reduced over time. He now has a significant headache about three to four times a week beginning in his neck. He feels tightness in his neck. It will increase and he feels a clenching in his jaw and a band-like sensation around his head. He has ongoing pain affecting his neck although this has also reduced in intensity. He has reduced range of motion but it is not as painful as it was before. He also has problems with bilateral shoulder pain and he has difficulty lifting his arms past 90 degrees in abduction. He then gets a pins and needles sensation down his arms. He describes his hands as at times flinging away whatever they may be holding like a "spasm".

Patient reports chronic low back pain. He describes it as a burning and aching sensation that is "horrible". The only time he gets relief is if he leans over something like a shopping cart. If he straightens up he then feels like he is getting "lightning bolts" into his legs. He feels that there is a flame thrower on his hips. He describes lack of sensation at the bottom of his feet as though he has meat tied to them and he is walking on this.

***Level of Function:(As of June 25, 2013)***

Prior to the accident Patient drove truck up to 16 hours per day averaging 60-75 hours per week. He worked out at a gym three times per week doing body building and he spent time with his children.

Patient described himself as having a very full and busy life prior to the accident. Often he worked over 60 hours per week. Although there were some days that he felt very exhausted he enjoyed his work. His route of work had also been changed and he found the route prior to the accident very pleasant. Just prior to the accident he had also had his car repainted. This was the car that was involved in the accident. At this time the patient weighed 240. He could bench press up to 550 pounds and squat about 600 pounds.

Now, Patient reports that he does very little. He wakes up anywhere from 7:30 to 9 o'clock in the morning. He will take his medications and it takes him about an hour to mobilize. He will have breakfast and then go for a walk every day. He reports the problem with walking is that he gets spasms down his leg and he has back pain. He may do some exercise like doing push-ups off of a wall in the vertical position. He does not have a clear exercise program. He might help his children. He cannot babysit but he might take his wife to one of his children's home to do the babysitting or he will help

to transport family members to various appointments.

He purchased a motorcycle to do some work on. Recently he tried to use it. He reported having trouble lifting his leg over the motorcycle to get on it. He took a ride around the block and then reported suffering for many days afterwards so his plan is to now sell the motorcycle. As he stated “I don’t know who I am anymore.”

He may watch some television in the afternoon or have a brief nap. He and his wife do not socialize much anymore. He generally does not like to be around other people. His wife indicated that he does try to do things around the home like mow the lawn but he may do only one pass and then she will finish the task. The same thing happens with doing the dishes. He may do half of them and then she will finish.

Intimacy is greatly reduced. The patient has no interest and he stated that this is now an issue between he and his wife. He is starting to think that because of this she will start to look for somebody else. He attributes this in part to the fact that she is 12 years younger than she is.

*It is important to recognize that long term, long acting opioid use can suppress testosterone production in men. Many of the patient’s symptoms might be as a result of low testosterone.*

In regards to sleep the patient tosses and turns all night long. His wife reports that he stops breathing when he is on his back and he describes waking himself up because he snores. He scored 14 on an Epworth Sleepiness Scale.

*I have referred this patient to the Sleep Disorders Clinic.*

When asked what Patient his wife’s understanding of his problems is, neither of them had a clear rationale as to why Patient is having such severe functional problems.

## PAST MEDICAL HISTORY:

In addition to what has been described Patient fractured his nose in a fight. He was bleeding excessively and it was a number of days before he came to surgery for cautery. During the surgery he had a cardiac arrest. He then had a second heart attack after that. However he has been recently examined and told that his heart does not show evidence of any significant damage.

**PAST PSYCHIATRIC HISTORY:**

Patient reports having a pre-accident history of a bit of anxiety but he stated that it was not particularly impairing.

Currently he is seeing a psychologist, Dr. XX, on a regular basis and he finds the input helpful.

**MEDICATIONS:**

ASA 81 mgs.

Hydrochlorothiazide 25 mgs

Ramipril 10 mgs bid

Tamsulosin .4 mgs once per day (prostatic hypertrophy)

Lorazepam 0.5 mgs prn typically taken daily

Lorazepam 2 mgs qhs

Oxy Neo 40 mgs q6-8h.

Zantac over the counter

In regards to the Lorazepam this patient has been using Lorazepam for many years for episodic panic attack.

*The use of benzodiazepines for this purpose is not ideal. However, it is always difficult to withdraw patients who have been using benzodiazepines for many years. Anxiety and panic is best treated with antidepressant therapy.*

Patient reported that he has had flashbacks because of the use of tricyclics antidepressants. He also reported that the most useful opioid was Oxycontin. Once it was changed to Oxy Neo he finds that the analgesia wears off after about four hours. For this reason he takes two tablets in the morning, one tablet about four hours later, one tablet four hours after that and two tablets at night. He did have trials of Hydromorph Contin and MS Contin, both of which he reported were not helpful.

*From a physiologic point of view only, this response is atypical given that all of these*

*medications are mu receptor agonists and this is how they reduce pain. No opioid has ever been shown to be better than another. However, it is also important to understand that patients can have idiosyncratic responses to medications.*
Patient also reports that he will develop withdrawal symptoms from the Oxy Neo well before the eight hour period of time. He does not like using the narcotics but when he has tried to decrease them his pain gets more out of control.

Patient is allergic to tree nuts, Demerol and Marijuana. The Demerol precipitated the second myocardial infarction described above. The patient does not smoke or use any substances. However, recently, he went out with a friend. He tried a couple of his friend's Percocets. He also had a couple of beers and he did two lines of Cocaine which he has not done in many years. The Cocaine made him feel extremely anxious and he decided he was not going to use substances anymore. It was also at about this time that his family physician did her first urine drug testing. The end result was that she was quite concerned about the patient's utilization of substances while he was also using opioids. Patient recognizes that his use of these substances was very ill-advised. He verbally reported that he was not going to do it ever again. It is important to note that Patient does have a past history of substance use while he was heavily involved in the biking gang. He stopped doing this since 2005. He recognizes that he is married with children and now has grandchildren and that it is very inappropriate to be using these types of substances. As well, with the recent involvement of heart related problems he also recognizes that this behavior is not good for his own health.

**PERSONAL HISTORY:**

Patient was born Toronto. He has three brothers and a sister. There is no history of trauma. He completed grade 12. He described himself as being a short fat kid who was often beaten up but over the years he started to work out and made sure that type of behaviour stopped. Ultimately he went on to join a biker's gang. He became an officer in the gang and when he was told to do some activities he was not comfortable with he decided to leave the gang and this took place about five years ago. While he was in the biker's group he did engage in poly substance abuse. He stopped doing this about two and a half years ago. He stated that he has never been charged.

The patient was first married at the age of 22 and he was chronically unfaithful to his wife. The marriage lasted about 11 years and then ended. There have been ongoing issues related to dealing with the wife. In his current relationship he describes his wife as very supportive.

**MENTAL STATUS EXAMINATION FROM DECEMBER 8, 2011:**

Patient presented as a pleasant, well groomed, athletic looking man. He ambulated with a cane and was accompanied by his wife. He reported feeling down most of the time. This is accompanied by irritability.

Patient reports losing 20 pounds and he will only eat about one meal per day. He has problems with middle insomnia. He reports anhedonia. His energy is low and he has very poor concentration. He has low libido and sexual dysfunction. He is being investigated by urology. He adamantly denied suicidal ideation or intent. There was no evidence of mania or hypomania.

Patient reports having spontaneous panic attacks particularly at night. They can happen for no reason. He is fearful of having a panic attack outside of the home. He is uncomfortable in crowds or in large open spaces or in crowded areas. He denied having nightmares related to the accident at this point in time and he denied having fears related to the accident stimulated by things going on in his day to day life. His thought form and content were normal and there was no evidence of perceptual disturbance. Cognitive examination was grossly normal.

**BRIEF PHYSICAL EXAMINATION FROM DECEMBER 8, 2011:**

A brief physical examination was conducted. The patient had functional range of motion of the neck and back but had pain at end range of motion in all directions both of the neck and back.

On palpating fibromyalgia tender points this patient was tender in 16 out of 18 tender points.

**MENTAL STATUS EXAMINATION FROM JUNE 25, 2013:**

Patient looks physically different than he has in the past. He has lost the athletic look that he initially had. He has become progressively heavier looking although his weight is relatively unchanged. As he indicated he is physically changing because he is not working out anymore. The patient displayed significant pain behaviours throughout the assessment. At times he also became quite tearful particularly when talking about the losses that he has experienced. He describes his mood as chronically down. He is not eating well. He reports eating about one meal a day but he also eats food that is not good for him and he knows this. Sleep has been described above and is characterized

by middle insomnia with significant daytime somnolence associated with snoring. Patient endorses significant anhedonia. His energy is very low as is his concentration. He described himself as having no confidence at all in himself anymore and he feels very badly about who he has become. He denied currently having suicidal ideation but he has episodically had passive thoughts of suicide.

Patient reports having episodic panic attacks. This has gone on since his 20's. Typically it has not been associated with severe avoidant behaviour. However since the accident he has become more avoidant of social situations. He feels that people are looking at him thinking negative thoughts. He feels that he has gone from being a strong somewhat intimidating looking man to being someone that people think is "crippled". As he stated they look at him and think "that old fool". The patient's thought form and content were normal and there was no evidence of perceptual disturbance. Cognitive examination was grossly normal.

**BRIEF PHYSICAL EXAMINATION FROM JUNE 25, 2013:**

A brief physical examination was conducted. The patient displayed functional range of motion of the neck. However, when going into flexion he suddenly reported severe low back spasm on the right. This occurred again when he rotated his neck to the right. He reported pain at end range of motion in all directions. The patient had 18 tender points but he also had pain at all control points. It took less than feather light touch to illicit reports of pain.

In terms of back flexion he could flex to about 20 degrees and again reported pain. With pseudo-rotation the patient reported severe low back spasm although spasm was not palpated.

At the end of the examination Patient reported that he had no feelings in his legs. The patient is more symptomatic as compared to my previous assessment.

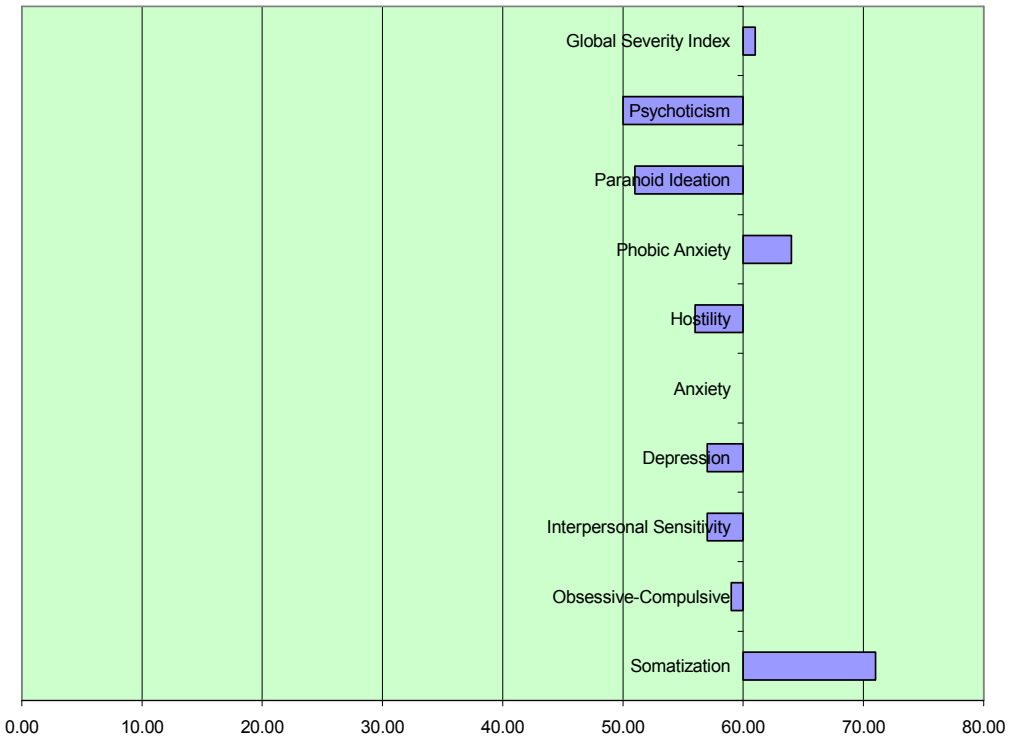
***SECTION II***

***The information in this section derives solely from objective psychometric testing.***

**PSYCHOMETRIC TESTING FROM DECEMBER 8, 2011:**

***Psychopathology:***

On the **SCL90-R**




On the SCL-90-R, subscales with T-Scores above 60 are considered to be clinically significant. Clinically significant elevations are noted for somatization, phobic anxiety and the global severity index which is a measure of psychological distress.

On the **ALCOHOL USE DISORDERS IDENTIFICATION TEST (AUDIT)**, Patient scored

2 which is below cut off indicating no issues related to alcohol use.

On the **DRUG USE DISORDERS QUESTIONNAIRE** Patient reported he last used marijuana in 2003 and cocaine in 2005.

On the **SOAPP,** scores above 7 indicate risk related to addiction to opioids during treatment. Patient scored 7.

On the **PAIN CATASTROPHIZING SCALE** scores above the 75th percentile are considered to be clinically significant. The patient's total score was in the 73rd percentile. On the rumination subscale he scored in the 75th percentile. On the magnification subscale he scored in the 86th percentile and on the helplessness subscale he scored in the 64th percentile. There is evidence of clinically significant catastrophic thinking.

On the **PTSD CHECKLIST** Patient's profile did not meet criteria for PTSD. He did not meet criteria A or B.

***Pain and Disability:***

On the **PAIN DISABILITY INDEX** Patient scored 52. This score is above scores typically seen in patients with chronic noncancer pain involved in litigation. For family and home responsibilities the patient scored 7 out of 10 with 10 being total disability. For recreation he scored 9 out of 10, for social activity he scored 9 out of 10. For occupation he scored 10 out of 10. For sexual activity he scored out of 10. For self care he scored 7 out of 10 and for life support activities he scored 1 out of 10.

Patient's **KARNOFSKY score** is 70 indicating that he can care for himself but is unable to perform normal activity or do active work.

On the **OSWESTRY BACK PAIN AND DISABILITY QUESTIONNAIRE** the patient scored 82 indicating that he is either bed ridden or amplifying symptoms.

On the **OSWESTRY NECK DISABILITY QUESTIONNAIRE** the patient scored 64 indicating that he perceives himself as crippled as a result of neck pain.

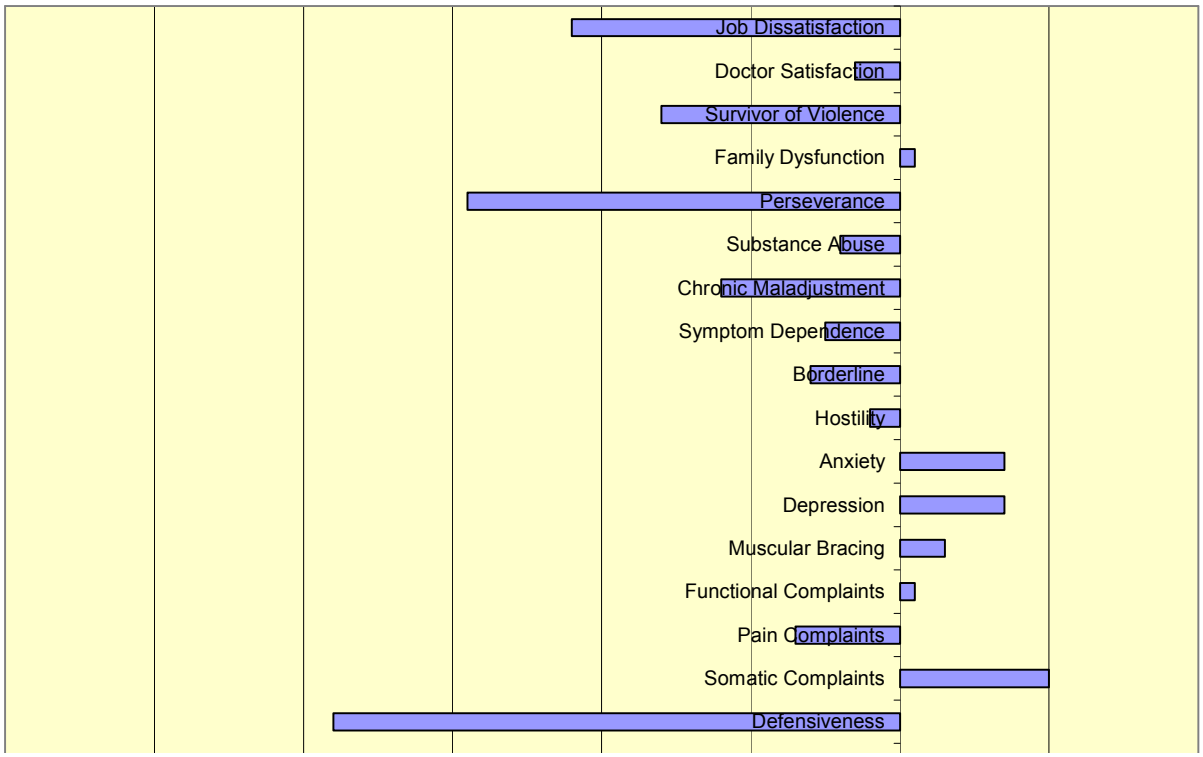
***Summary of Findings:***

The patient endorses somatization, anxiety and global psychological distress. He has evidence of catastrophic thinking. He perceives himself as bedbound as a result of axial spine pain.

**PSYCHOMETRIC TESTING FROM JUNE 25, 2013:**

***General:***

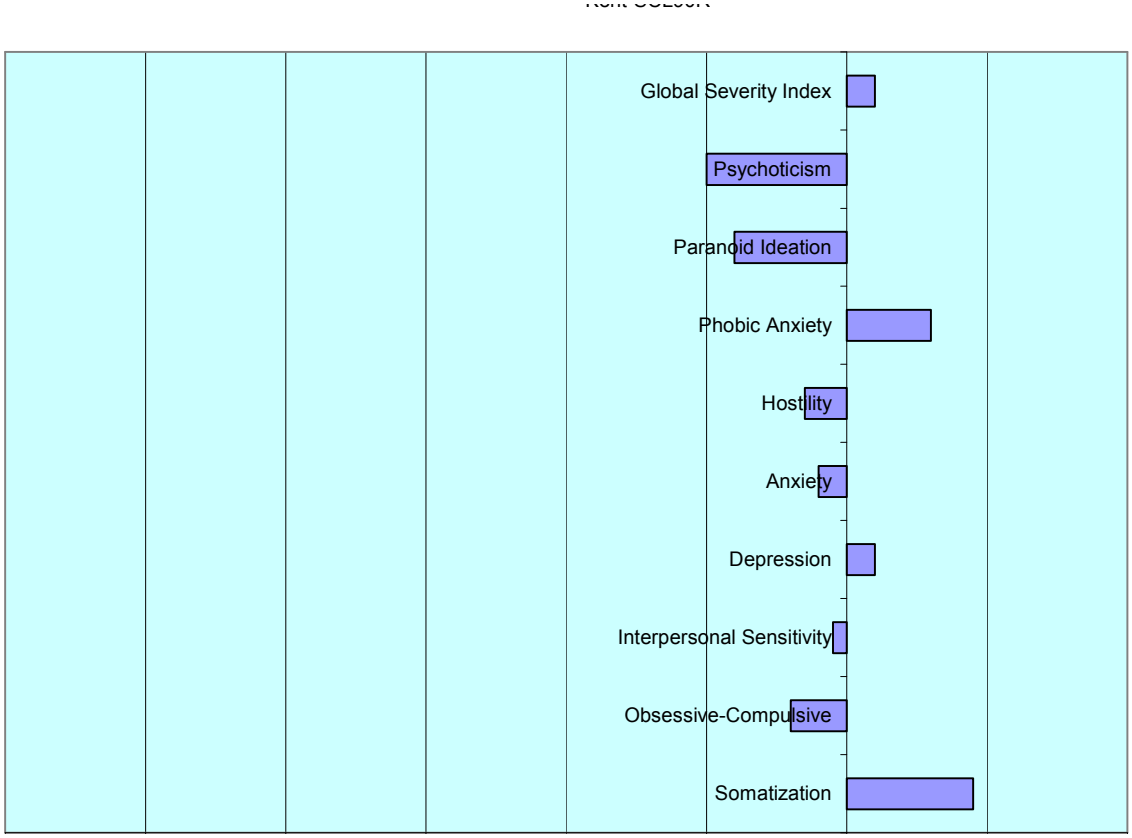
On the **BEHAVIOURAL HEALTH INVENTORY II**




Scores above the 60th percentile are clinically significant. Elevations on noted for somatic complaints in keeping with somatization. The subscales for functional complaints and muscular bracing are elevated in keeping with chronic pain. The patient reports depressed mood, anxiety, and family dysfunction.

***Psychopathology:***

On the **SCL90-R**




Subscale scores above 60 are clinically significant. Elevations are noted for somatization, depressed mood, phobic anxiety and global psychological distress.

On the **PTSD CHECKLIST** Patient 's profile did not meet criteria for PTSD.

On the **ALCOHOL USE DISORDERS IDENTIFICATION TEST (AUDIT)**, Patient scored 2 indicating that he does not have current problems with alcohol abuse.

On the **DRUG USE DISORDERS QUESTIONNAIRE** Patient indicated he used marijuana in 1999 and used cocaine recently in 2013. This is something that will be explored at his assessment.

On the **SOAPP** scores above 7 indicate concerns related to the use of opioids for the treatment of chronic pain. Patient scored 8. This score indicates that Patient's use of opioids should be closely monitored.

On the **PAIN CATASTROPHIZING SCALE** scores above the 75th percentile are considered to be of clinical significance. Patient 's total score was in the 85th percentile. On the rumination subscale he scored in the 50th percentile. On the magnification subscale he scored in the 75th percentile and on the helplessness subscale he scored in the 83rd percentile. Patient has clinically significant cognitive distortions related to magnification and helplessness.

On the **EPWORTH SLEEPINESS SCALE** Patient scored 14. This will also be explored at the assessment.

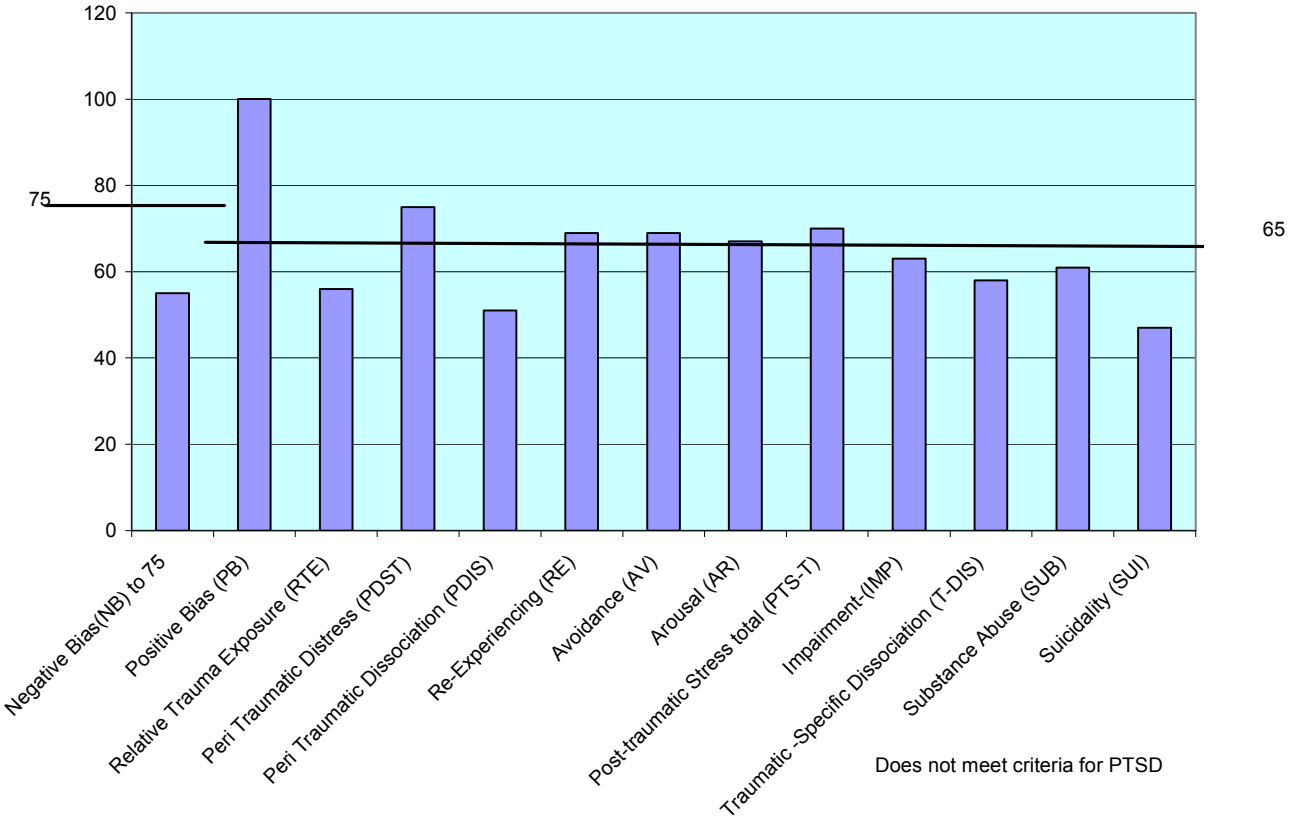
On the **DAPS**

**The Detailed Assessment of Posttraumatic Stress (DAPS) Scale** is a 104-item, detailed, and comprehensive clinical measure of trauma exposure and posttraumatic stress in individuals ages 18 years and older who have a history of exposure to one or more potentially traumatic events. The instrument assesses peri- and posttraumatic symptoms (e.g., intrusion, avoidance, hyperarousal) and associated features (e.g., dissociative symptoms, substance abuse, suicidality) related to a specific traumatic event and generates a tentative diagnosis of Posttraumatic Stress Disorder (PTSD) or Acute Stress Disorder (ASD) in considerably less time than is required for a structured diagnostic interview. The diagnosis can then be confirmed by a clinical interview.

The subscales are (see appendix for more detail):

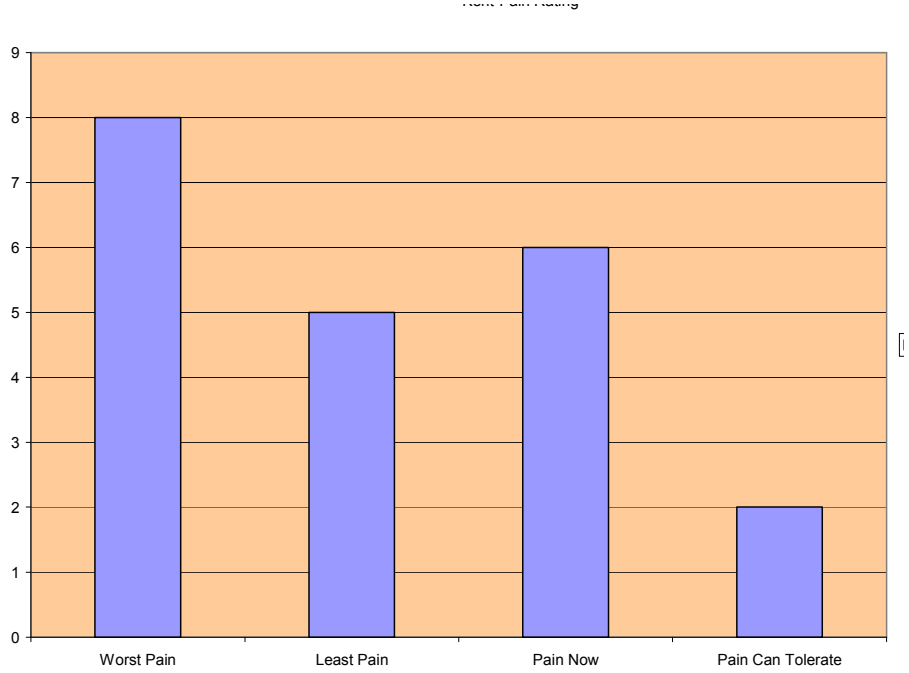
Positive Bias (PB), Negative Bias (NB), Relative Trauma Exposure (RTE), Onset of exposure (ONSET), Peritraumatic Distress (PDST), Peritraumatic Dissociation, Re-experiencing (RE), Avoidance (AV), Hyperarousal (AR), Posttraumatic Stress Total (PTS-T), Posttraumatic Impairment (IMP), Trauma Specific Dissociation (T-Dis), Substance Abuse (SUB), Suicidality (SUI).

Patient's profile does not meet criteria for PTSD.


120
100
80
60
40
20
0
75
65
Negative Bias(NB) to 75
Positive Bias (PB)
Relative Trauma Exposure (RTE)
Peri Traumatic Distress (PDST)
Peri Traumatic Dissociation (PDIS)
Re-Experiencing (RE)
Avoidance (AV)
Arousal (AR)
Post-traumatic Stress total (PTS-T)
Impairment-(IMP)
Traumatic -Specific Dissociation (T-DIS)
Substance Abuse (SUB)
Suicidality (SUI)
Does not meet criteria for PTSD

***Pain and Disability:***

On the **PAIN RATING SCALE:**




On the **PAIN DISABILITY INDEX** Patient scored 49. This score is in keeping with scores typically seen in patients with chronic noncancer pain involved in litigation. For the family and home responsibilities subscale he scored 7 out of 10 with 10 being total disability and 0 being no disability. For the recreation subscale he scored 9. Social activity was scored at 9, occupation at 10, sexual activity at 9, self care at 5 and life support activities at 0.

On the **HAND SORT**, Patient 's score was in the 25$^{th}$ percentile indicating sedentary capacity.

On the **SPINAL SORT,** Patient 's score was in the 15$^{th}$ percentile indicating below sedentary capacity.

On the **OSWESTRY BACK PAIN AND DISABILITY QUESTIONNAIRE** Patient scored 80. This is right at the cut off indicating this patient is either bed bound or exaggerating symptoms.

On the **OSWESTRY NECK DISABILITY QUESTIONNAIRE** Patient scored 64 indicating that he perceives himself as crippled as a result of neck pain.

Patient 's **KARNOFSKY** score is 70. This indicates that he can care for himself but is unable to perform normal activity or do active work.

On the **HEADACHE IMPACT TEST** Patient scored 62 indicating that he perceives himself as having headaches that are impacting all aspects of his life.

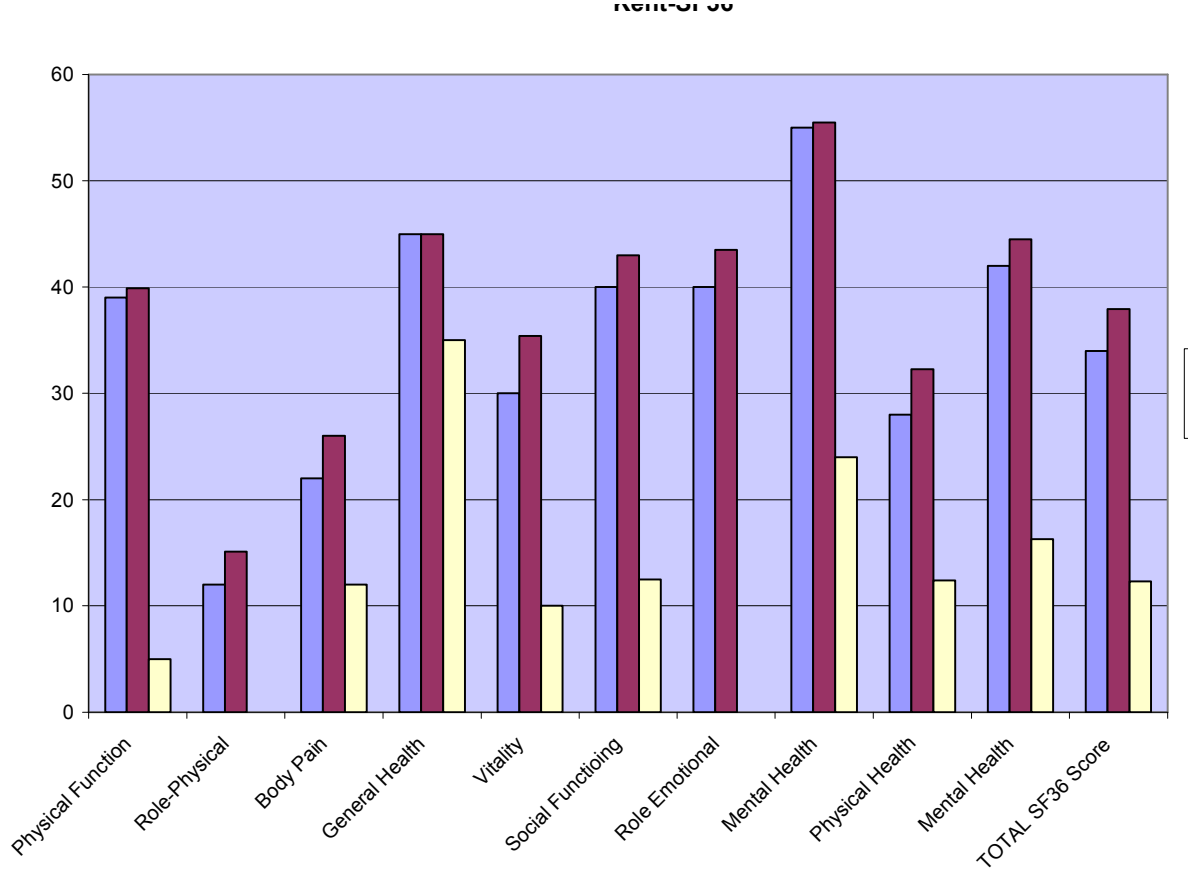
On the **OREBRO MUSCULOSKELETAL PAIN QUESTIONNAIRE** scores above 130 indicate extremely high likelihood of chronic disability and very low likelihood of return to work. Patient scored 174.

On the **TIMED TO GET UP AND GO TEST** Patient scored 33 indicating impaired mobility.

On the **FEAR AVOIDANCE QUESTIONNAIRE** Patient scored above cut off in both the work and physical subscales.

On the **TAMPA SCALE OF KINESIOPHOBIA** Patient scored 47. This score indicates fear of movement.

Patient ’s score on the **SF36** is:




The SF-36 contains 36 items that, when scored, yield 8 domains. Physical functioning assesses limitations in physical activities, such as walking and climbing stairs. The role physical and role emotional domains measure problems with work or other daily activities as a result of physical health or emotional problems. Bodily pain assesses limitations due to pain, and vitality measures energy and tiredness. The social functioning domain examines the effect of physical and emotional health on normal social activities. Mental health assesses happiness, nervousness and depression. The general health perceptions domain evaluates personal health and the expectation of changes in health. All domains are scored on a scale from 0 to 100, with 100 representing the best possible health state. Summary scores for a physical component (physical functioning, role physical, bodily pain and general health perceptions) and a mental component (vitality, social functioning, mental health and role emotional) can also be derived.

The patient's score is compared to a large, cross country cohort of patients with chronic non-cancer pain. Patient's score is below comparison groups across all subscale scores. His reported level of function is more in keeping with an individual who is bed-bound suggesting that this is how Patient perceives his level of activity.

On the **DISABILITY OF THE ARMS, SHOULDER AND HAND (DASH)** Patient scored 104. This score is well above scores typically seen in patients with arm, wrist and hand pathology suggesting symptom amplification.

On the **LOWER EXTREMITY FUNCTIONAL SCALE** the score is 10%. This puts the patient in the criteria of being bedbound or exaggerating symptoms.

***Cognitive Ability:***

On the **MONTREAL COGNITIVE ASSESSMENT SCALE** Patient scored 30 out of 30 indicating no problems related to cognitive capacity.

On the **WONDERLIC INTELLIGENCE SCALE** Patient scored 22 indicating a WAIS score of 104 which is average.

***Malingering:***

On the **REY 15 ITEM MEMORY TEST** Patient scored 15 out of 15 indicating no issues related to exaggeration of cognitive difficulties.

On the **REY DOT COUNT TEST** Patient scored 13 again indicating no issues related to cognitive difficulties. Typically the REY 15 Item Memory Test and REY Dot Count are utilized in the assessment of malingering.

On the **REHABILITATION CHECKLIST** the patient did not complete the first section properly and therefore the data is not valid. On the degree of life support disability Patient indicated he is 100% disabled from sports and hobbies and regular employment. He is 90% disabled in regards to household chores, community and volunteer work, sexual activity and social activity. He is 80% disabled in regards to parental activity and relationship with his spouse and partner. He is 70% disabled in regards to relationship with friends and family and overall how disabled he perceives

himself. He is 60% disabled in regards to self sufficiency such as eating and dressing and 40% disabled in regards to learning.

His condition has changed since the accident by 70% in regards to becoming worse. Emotionally he perceives himself as 90% worse since the accident. In the future he expects that he will become 30% worse. He indicated that he will never be able to do most of his normal activities and he stated that it will take more than a year before he will be able to do some form of work.

***Summary of Findings:***

On psychometric testing Patient is of average intelligence. Overall he feels 70% disabled. There is evidence of somatization, anxiety and depressed mood. A number of his scores suggest symptom exaggeration and a self perception of profound disability. His perception of his function is very low. There is evidence of catastrophic thinking, fear and avoidance and fear of movement.
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***SECTION III***

***The information in this section derives solely from the available medical-legal brief.***

**REVIEW OF AVAILABLE DOCUMENTATION*:***

*Notes that are handwritten and photocopied will be commented on if they are completely legible only. Documents will be commented on only if they are complete and are not missing any pages.*

***Primary Care Physician Notes:***

The vast majority of these notes are not legible.

A note from July 7, 2008 states the patient went off Metroprolol because it made him feel tired. He was also complaining of panic. He has uncontrolled hypertension.

A note from August 18, 2008 states the patient has problems with lipids.

A note from September 22, 2008 states the patient is describing "having lots of anxiety". He denies excessive use of alcohol or substances. He was started on Cipralex.

A note from November 17, 2008 on Cipralex the patient started to have violent thoughts. He was also using Lorazepam. The plan is to potentially give the patient a leave from work for stress.

A note from January 9, 2009 states the patient is taking Lorazepam for anxiety.

*Benzodiazepines (lorazepam) are not the ideal medication for the management of anxiety. This patient has had issues related to anxiety that pre-date the accident. His use of lorazepam predates the accident.*

A note from March 27, 2009 notes the rear end collision two weeks prior. It states that Patient was not wearing his seat belt and he has had problems with dizziness and back pain. The anxiety that he has is described as stable.

A note from April 14, 2009 pain is described as persisting.

A note from May 7, 2009 states pain is described as better with Nortriptyline.

A note from May 21, 2009 states the patient is describing paraethesias as well as neck pain and headache. Imaging is reviewed.

A note from 2009 (the rest of the date is not legible) indicates the patient's pain is controlled with 40 mgs of Oxycontin q8h and 50mgs Nortriptyline. He was having problems with erectile dysfunction.

*A common side-effect of nortriptyline is erectile dysfunction.*

A note from October 22, 2009 states the patient is complaining of increased low back pain.

A note from January 6, 2010 states the patient is diagnosed with "situational depression" and anxiety

*The term situational depression is anachronistic and not utilized in psychiatry anymore.*

A note from February 23, 2010 states that Patient reports he did not try Cymbalta which had been recommended because he was feeling generally better and was getting out more.

A note from March 30, 2010 states that Patient is reporting increased weakness in the lower extremities with shooting pain and spasm. The patient's wife is upset because changes in the patient have affected their marriage.

A note from April 13, 2010 states the patient is being treated with cyclobenzaprine.

A note from November 5, 2010 it is reported that surgery got delayed due to anxiety. He had a trial of Remeron but he also increased nightmares. It is stated that Lorazepam is not appropriate and there is concern about dependence.

A note from May 4, 2011 states the patient saw Dr. XX in the spine clinic at the Hamilton General. He is being referred to neurosurgery.

***ER Report dated 19/1/86:***

Patient is presenting with flushing and tacky arrhythmia and he is diagnosed with palpitations.

***ER Report dated 29/03/89:***

Patient was involved in a motor vehicle accident. This was a rear end collision. The note is difficult to read.

***Chest X-ray dated 29/03/89:***

There is some question of degenerative change at C5-6 and disc space narrowing at that level is noted.

***ER Report dated 1/5/93:***

Illegible.

***Plain Film X-rays of the Spine dated 1/5/93:***

No abnormalities identified.

***ER Report dated 14/12/93:***

Patient reported back pain of ten years which was aggravated. He was also having anxiety attacks. The primary diagnosis is anxiety and panic attacks. He was being treated with Ativan.

***CT of the Spine dated 4/5/94:***

Centrally bulging disc at L5-S1.

***ER Report dated 24/6/01:***

Patient reported pumping gas and developed sudden onset of shaking, sweating and nausea with mid sternal chest pain and anxiety. He was concerned he was having an anxiety attack. He was diagnosed with anxiety attack and given Indapamide. He was given a list for counseling and there was also a question of hormone supplementation.

*Indapamide is used for the treatment of hypertension. It is unclear why is was*

*prescribed to Patient. No details were provided in regards to 'questions of hormone supplementation'.*

***Ambulance Call Report dated April 3, 2009:***

There was no loss of consciousness an no air bags deployed. Patient was complaining of low back pain particularly on the right side with radiating pain down to the arch of the foot. He also was complaining of rib pain. It was stated that he had good grip strength and there were no other significant findings noted in this report.

***Emergency Room Cover Sheet dated 3/4/09:***

This document is not legible.

***Nursing Notes dated April 3, 2009:***

Patient was the driver of a car when he was broad sided on the right side. He took himself out of the car and was ambulatory at the scene and had tenderness in the right side of the back, right leg and arch of the foot. He was brought into the hospital on a backboard with collar which was taken off. He has allergies to Demerol and bruising was noted to the left chest from the seat belt. At this time Patient was using Altase, Bisoprolol, ASA and Lorazepam.

During the time in hospital Toradol (NSAID) was ordered and Patient was discharged home and advised to return if pain increased in severity. He was advised to use over the counter Tylenol and follow up with the primary care physician.

***X-rays of the Pelvis and Lumbar Spine dated April 3, 2009:***

Multilevel degenerative changes note

***MRI of the Cervical Spine dated 30/06/09:***

No evidence of any focal disc herniation or cental canal stenosis with mild narrowing at C3-4 and C4-5.

***Neurological Report completed by Dr. XX (neurologist) dated August 11, 2009:***

Patient is being assessed for dizzy spells and leg pain. Cognitive exam was done at the bedside. Neurologic examination did not identify any significant findings. Nerve conduction EMG were performed.

*Could not find the EMG report.*

***MRI of the Brain dated 11/09/09:***

No intercranial abnormalities identified.

***MRI of the Lumbar Spine dated September 29, 2009:***

Central canal stenosis at L4-5 and L3-4 with indenting of the thecal sac at L5-S1. There is a trefoil thecal sac at L5-S1 that relates to epidural fat. There is developmental narrowing of the central canal with short pedicals at L4-5 and superimposed on a broad based posterior disc protrusion.

***Report by XX (PT), dated September 29, 2009:***

The accident is described and Patient's complaints are noted. On examination there is reduced range of motion in the axial spine with pain on movement of both shoulders. There was some weakness in the right shoulder. There was some decreased sensation in the right inner leg and lateral foot.

It was the opinion of the assessor Patient had cervical strain and thoracic strain and lumbar strain with "possible disc herniation and right shoulder strain". Recommendations are made for exercise program and "pain skills program".

***In Home Functional Assessment Report completed by XX (OT) dated November 25, 2009:***

The accident is described and prior to the accident Patient reported being independent in personal care. He worked full-time and had long hours. He would spend his free time at a local gym and working with his brother at a body shop. During the assessment Patient walked with a cane. He would use walls or furniture for support in the home and demonstrated continuous weight bearing. He had functional range of

motion of the lower extremities and functional strength but testing increased pain and caused “observable spasms of his legs”. He had limitations with upper extremity mobility and limitations with cervical rotation and lateral flexion and limitations in lumbar flexion movement. He was unable to crouch or kneel. He required assistance getting out of a bed and reported an inability to perform tub transfers without assistance.

It was the opinion of this examiner that Patient demonstrated a need for attendant care. At the time of the assessment the current monthly allowance was $507.17. At the time of this assessment it was the opinion of the assessor that the patient required $559.59 of attendant care.

***Psychological Report completed by XX (psychologist) dated February 25, 2010:***

The accident is described as well as Patient’s personal history. Typical psychological tests are utilized.

On the BECK Depression Inventory the patient scored in the severe range and Patient has severe feelings of helplessness.

On the BECK Anxiety Inventory the patient scored in the severe range.

There are significant elevations across a number of scales in the Personality Assessment Inventory suggesting significant distress and impairment in function. There is evidence of anxiety, depressed mood and somatic preoccupation. There is evidence of emotional lability.

Patient was given the Trauma Symptom Inventory. There is questionable validity and there is also evidence of exposure to trauma suggesting PTSD. The validity scales are considered within permissible limits.

On the Westhaven Yale Multidimensional Pain Inventory Patient’s perception of pain is higher than a comparison group. Interference of pain is above average. Emotional distress is above average. He has lower than average control over pain and higher than average degree of emotional support and average frequency of punishing response to pain. His overall level of activity is lower than average compared to a normative sample of pain patients.

The Pain Depression Index is utilized but it is not scored appropriately and it is concluded Patient perceives himself as being totally disabled.

On the Salmon Rehabilitation Checklist the five most important factors that restrict his function are physical restrictions, pain, emotional problems, depression and sexual

dysfunction. Overall he sees himself as 90% disabled and he is extremely disabled in doing household chores, parental activity and relationship with his spouse, sexual activity and self sufficiency. He had severe disability in relationship with family, volunteer work in the community and learning and studying. His condition has worsened by 20% and his emotional condition by 70%. He believes his condition will improve by 100% in the future and he expects to be well enough to eventually carry out normal activities and do regular work.

Based primarily on test results, Patient is diagnosed with depressive disorder, non organic sleep disorder , posttraumatic stress disorder, chronic pain and headaches and other unspecified symptoms and signs of altered cognitive function as well as relationship difficulties. Recommendations are made for individualized psychotherapeutic input.

*Individual treatment can be helpful in the management of depressed and anxious mood. There is no significant evidence that this treatment format is helpful for chronic pain.*

***Occupational Therapy Attendant Care Progress Report completed by XX (OT) dated March 3, 2010:***

At this point Patient requires $891.56 of attendant care as well as 9.5 hours per week of assistance in housekeeping. There is also recommendation for assistive devices.

***Report completed by XX dated March 8, 2010:***

Patient is presenting with right leg pain following the accident of 2009 with burning and numbness in the leg and sole of the foot. The patient has reduced range of motion of the lumbar spine but there was no evidence of neurologic deficit. He was unable to do a straight leg raise testing because of severe pain. There were degenerative changes throughout the lumbar spine on MRI but there was no role for surgical intervention. He needs to be managed “with a physiotherapy and exercise type program”.

***Consultation Report completed by XX dated 13/04/10:***

Patient was referred for a neurosurgery consultation in the spine clinic for low back and leg pain. He is noted to have coronary artery disease dating from 2005. However “it seems that was secondary to stress due to excessive bleeding from his nose at that time which cauterized at that time (sic)”.

Patient reported having symptoms since 2009 when he was involved in a car accident complaining of neck and back pain with episodic numbness in his legs and give way of the legs. There is a history of some erectile dysfunction.

On examination Patient ambulated with a cane with an antalgic gait. He could not walk on his toes because of weakness. Cranial nerve examination was normal. There was evidence of Hoffman's sign in the upper extremity. There was also decreased sensation in the right C7-8 but power was 5 out of 5.

MRI at this time suggested multi level spinal canal stenosis and the thought was to limit procedures to one level laminectomy but due to diffuse symptoms and stenosis they state it might be better to do a general decompression from L3-L5 with laminectomy and foraminotomy. They were going to repeat the MRI prior to any decision about surgery as well as flexion extension views.

***Report completed by XX (urologist) dated May 25, 2010:***

Patient is described as having a longstanding history of moderate irritative and obstructive urinary symptoms that are moderate to severe. The accident is noted as well as MRI findings. Prostate examination was normal. The plan is to use Ofloxacin for a three week trial and do PSA studies with follow up.

***In Home Functional Assessment Report completed by XX (OT) dated September 18, 2010:***

The question was again asked if Patient is entitled to attendant care benefit and the assessor said yes and the amount of benefits is $1575.

***Report completed by XX (neurosurgeon) dated September 21, 2010:***

Patient's symptoms are described and it is recommended he needs a repeat MRI and then review for potential surgery. This is in response to the fact that he did have an MRI but it had to be cancelled because the patient could not stay still.

***MRI of the Lumbar Spine dated 24/09/10:***

Multilevel degenerative change and disc protrusion with slight interval increase in the

degree of spinal stenosis since previous examination. There is disc protrusion from T11 to T12. These are the areas that have been examined.

***Report completed by XX (neurosurgeon) dated October 26, 2010:***

Patient has symptoms of lumbar neurogenic claudication in both legs and the recommendation is made for posterior decompressive laminectomy at L3-4 and L5-S1 with microdiscectomy. The patient wished to proceed with surgery.

***Occupational Therapy Attendant Care Progress Report completed by XX (OT) dated February 1, 2011:***

It is concluded that Patient requires $3,096.06 of attendant care and 9.5 hours per week of housekeeping assistance as well as a number of assistive devices.

***Functional Abilities Evaluation completed by XX (certified functional evaluator, chiropractor) dated February 4, 2011:***

Patient was observed for one and a half hours during the assessment. He used a cane. It is stated there was consistent effort. The patient declined to perform the majority of lifting tests and therefore his current strength and capacity remains undetermined.

*Functional abilities evaluations are not particularly helpful in being able to predict a patient's capacity to work.*

***Report completed by XX (neurosurgeon) dated February 15, 2011:***

Patient had been awaiting spinal surgery and he was seen again because of "increasing back pain and leg pain". It was noted the patient had back and leg pain and limited straight leg raising and decreased sensation in the limbs bilaterally. His quality of life is poor and he does have spinal canal stenosis waiting for surgical intervention. There is a long waiting list and the case was discussed with Dr. XX (neurosurgeon with spinal subspecialty) to see if he would provide Patient with earlier surgical intervention.

***Job Site Analysis as a Driver of a Fat and Bone Pick Up Truck completed by XX dated March 11, 2011:***

Patient had worked at this job since May of 2006. The name of the company is XXXXX "an international industrial renderer transforming organic waste into cattle feed, biofuel, hides and skins".

Patient's work meets criteria for what is referred to as lime haul and local truck driving. The position requires heavy strength which is 51-100 pounds 33% of the workday and 26-50 pounds 66% of the workday.

***Independent Orthopedic Evaluation completed by XX (orthopedic surgeon) dated March 16, 2011:***

The nature of the accident is described briefly. On examination he was noted to have "quite normal postural curves". He was described as a large powerfully built male. He had reduced range of motion of the lumbar spine. Straight leg raising was 90 degrees and equal. He could not tolerate lying prone. Hip rotation on the right caused pain. Abduction while lying on the back caused pain and log rolling of this left hip resulted in pain. Ankle reflexes were absent. Reflexes in the biceps was trace but negative for triceps and brachial radialis. He could not tolerate all of the physical exam.

Available documentation was reviewed.

It was the opinion of this examiner Patient was "very difficult to treat". He described him as intimidating to someone who would like to encourage him to do more activities and he described his wife as solicitous who appeared to be willing to do everything for the patient. He also described Patient as suffering from a certain amount of anxiety and tension.

He stated that "all of these work together to create a lot of muscle tightness, while splinting and guarding protectionism". He stated that Patient has spinal stenosis and minor disc herniation which "certainly were not caused by the accident".

He stated it was questionable whether these problems were aggravated by the accident.

Patient describes severe leg pain without neurologic findings. There might be hip problems but the assessor did not have x-ray reports. He did wonder about groin pain related to prostatitis or changes within the hip "again that would not be related to the accident either".

It was his opinion that Patient was waiting for surgery but he felt the prognosis was "extremely limited". He described the patient now has "total dependancy on narcotic medication".

It was the opinion of this assessor that he was unable to find any injuries caused by the accident. He described Patient's presentation as grossly out of keeping with the physical findings. He could not find anything that would indicate that the patient has a substantial inability to perform the essential tasks of his employment or home maintenance or housekeeping. The assessor stated there was no indication for physical restriction.

***Report by XX (psychologist) dated March 29, 2011:***

Based on qualification Dr. XX's work involves work for the Correctional Services and he does psychovocational consultation.

*I found no evidence that this assessor has specialized skill in the treatment or evaluation of patients with chronic pain.*

The accident is described as well as Patient's current complaints and personal history. Typical psychometric testing is utilized including the SIMS. It is stated that Patient's score was above cut off on two of the five clinical subscales.

*The SIMS has been reviewed in the medical literature and it has been recommended that threshold scores need to be increased when the test is utilized with patients with chronic noncancer pain. Otherwise there is a significant risk of false positives.*

On the Personality Assessment Screener there is evidence Patient is at risk for clinical problems. There was evidence the patient is worried about physical functioning.
On the BECK Depression Inventory Patient's score put him in the severe range and on the Anxiety Inventory in the severe range.

On the PIII he was above average on measures of depression, anxiety and somatic complaints.

*It is important to recognize that the patient has seen these tests multiple times.*

Based primarily on limited psychometric test results, Patient is describing having adjustment difficulties contributing to symptoms of depression and anxiety as well as chronic pain and symptoms of "posttraumatic stress that would appear to be in remission".

Patient stated that pain was the primary factor preventing him from returning to normal activities. “Thus his emotional condition does not appear severe enough to contribute to a substantial inability to engage in pre-accident employment or housekeeping maintenance activities.”

*It would appear that this assessor is assuming that Patient’s pain problems are physically based and not psychiatric. I have a clinical disagreement. This assessor is a psychologist and therefore he does not have the expertise to comment on the medical factors of this patients pain.*

Patient is diagnosed with an adjustment disorder with mixed anxiety and depressed mood, chronic mood and posttraumatic stress disorder in remission. It is stated that his prognosis is excellent and this is based on the fact that the patient reported positive benefit from attending psychological treatment and that he was described as a “resilient individual”.

*This accident occurred in 2009 and the assessment is now taking place in 2011 without any appreciable improvement in this patient. Contrary to the assessor’s optimistic conclusion about prognosis, the prognosis is poor. This is supported by the medical literature. His response to psychological input is equivocal. Patient reports that he likes to get things ‘off (his) chest’. He does not report a significant response to this treatment.*

The assessor concludes that Patient has a psychological impairment that is not severe enough to contribute to a substantial inability to engage in his work.

*As noted above, I have a clinical disagreement with this assessor.*

It is concluded that Patient does not have a psychological disability but his psychological symptoms are materially related to the accident. Finally the assessor states that it is not within his expertise to comment on physical or functional restrictions.

***Report completed by XX (social worker), XX (psychologist) dated August 17, 2011:***

Patient is being assessed in regards to anxiety. He has been having panic attacks with dizziness and de-realization. He has fear of losing control with evidence of autonomic hyper arousal. He has fear in social situations. He has low mood. There is also chronic ongoing worry.

Patient is diagnosed with a panic disorder with agoraphobia, social phobia, generalized

anxiety disorder, major depression, posttraumatic stress disorder and specific phobia related to water and heights with a GAF of 60. He has been put on the waiting list for a CBT panic disorder group. It is stated the patient is going to see Dr. XX.

*In my opinion Patient has been 'over diagnosed'. His primary presentation is of a social phobia. I found no evidence of PTSD. It is possible that he was symptomatic with PTSD at the time of this assessment and this disorder is now in remission.*

***Physiotherapy Report by XX (physiotherapist) dated October 19, 2011:***

Patient is presenting with low back pain, bilateral leg pain, knee pain, headaches, disaesthesias, dizziness, problems with sleep, anxiety and right shoulder pain. On examination there are significant changes in range of motion involving lumbar spine and cervical spine with some reduction in power in the shoulder and wide spread tenderness on palpation. It is reported the patient has a positive finding for slump test, empty can test and it was their opinion Patient had weakness at L4-5 and S1.

It was the opinion of the assessors that Patient would benefit from "pain management" and range of motion exercises.

*What is meant by Pain management is not described.*

Recommendations are also made for massage therapy.

*Massage therapy is a passive treatment and there is no support in the medical literature for its use in patients with chronic noncancer pain.*

***Occupational Therapy PGAP Termination Report:***

This is the progressive goal attainment program that Patient participated in.

The accident is described. Documents are reviewed. It is stated Patient was active in all aspects of treatment. He scored high on a test of pain severity that was relatively unchanged pre and post. It states the patient at this point is still using TENS machine and heat packs. His spouse rubs and massage him as required.

*The patient is relying on multiple passive treatments.*

A measurement of depression is also used. There is no significant clinical change on

scores pre and post. The same is true on a measure of fatigue. The same was true of a test used to measure self reported limitation in function.

There was no significant change on measures of cognitive reaction to Patient's current symptoms or the degree to which Patient perceives what has occurred to him as being unfair. There is also a questionnaire in regards to the patient's worries and concerns that he might engage in activities that could result in exacerbation of symptoms and again no significant change is identified.

It is stated that throughout the program Patient was identified as having significant difficulty. His wife attended all sessions and was described as supportive. The patient reported that he had returned to participating in some housekeeping and light home maintenance by the end of the program and some social activities.

*Unfortunately these gains were not sustained.*

It was concluded Patient requires ongoing intervention to assist him to gradually increase his physical activity in a safe manner.

***Report completed by XX (psychiatrist/pain specialist) dated December 8, 2011:***

This is a section 24 assessment (now 25). At that time I diagnosed Patient with a pain disorder associated with both psychological factors and a general medical condition, major depression and panic disorder with agoraphobia.

*Over the course of time Patient's symptoms of anxiety have become clearer. His diagnosis is of a social phobia.*

I did recommend that the primary focus of treatment would be non medication based management strategies. Specifically I did recommend treatment in a multidisciplinary pain program.

***Addendum Report completed by XX (psychiatrist/pain specialist) dated December 8, 2011:***

At this time I diagnosed Patient with pain disorder associated with both psychological factors and a general medical condition, major depression and panic disorder with agoraphobia. It was my opinion that Patient suffered a serious and permanent impairment. Physical medicine assessments had indicated the patient's level of pain and disability were greater than expected and that in my opinion he had a pain disorder.

It was my opinion that Patient's level of impairment had a negative impact on his capacity to return to gainful employment for which he was reasonably suited by prior education, training or experience.

Finally, in my opinion the prognosis was guarded. Patient had been symptomatic since 2009 and his level of function continued to deteriorate.

***Psychological Report completed by XX (psychologist) dated December 29, 2011:***

It was stated Patient has participated in the therapeutic process with some improvement in his "emotional lability". The treatment was described as being focused on helping the patient "decrease the distress he experiences from his difficulties". Patient is reporting deterioration in his relationship with his spouse and he is having problems managing anger. It is stated the patient continues to have symptoms of PTSD.

An additional 16 sessions of psychotherapy is requested.

***Psychiatric Assessment Report completed by XX (psychiatrist) dated February 28, 2012:***

A number of documents are reviewed. My Section 24 is noted and reviewed as well as my treatment plan. XX reviews the accident and Patient's current complaints. She reviews activities of daily living, past history, personal history and she uses several commonly used psychometric tests.

On the BECK Depression Inventory the patient scored in the severe range and on the Anxiety Inventory he scored in the severe range.

On the PTSD Checklist Patient scored 49 which indicates significant symptoms of PTSD. On the Mood Disorder Questionnaire the patient's response did not indicate bipolar disorder and on the AUDIT Patient scored 1. He was also administered the Structured Clinical Interview for the DSM IV Personality Disorder or the SCID II. He presented with avoidant obsessive compulsive and borderline personality traits.

It was Dr. XX's opinion Patient presented with a major depressive disorder and pain disorder associated with both psychological factors and a general medical condition and anxiety disorder NOS. He was described as having mixed personality traits and his global assessment of function was 50. It states that he is clearly motivated to improve his life and he has been proactive in treatment. She concludes "he should benefit greatly from Dr. XXs' pain program".

It was her opinion that the treatment plan for a multidisciplinary pain program was reasonable and fees charged were described as reasonable.

***Report completed by XX (psychiatrist/pain specialist) dated June 27, 2012:***

I saw Patient individually. There were issues about him attending the pool program while in the pain program. I contacted Ms. XX who is the head of the pool program. Her intent was to use her experience in dealing with children with phobias to help Patient as an adult. She and I were going to get together to discuss how to do this more clearly. The patient also reviewed the significant financial loss he had suffered since the accident.

***Discharge Summary Report completed by XX (psychiatrist/pain specialist) dated September 14, 2012:***

Patient attended the program from May 4 to July 26, 2012. He was an active participant in all aspects of the program. The issue of the pool was discussed in that Patient had a previous near drowning resulting in fear of water. However with encouragement he was able to participate in the aquatherapy program. From his point of view Patient felt it was the only good thing he had done in the previous three years. He developed a social network and he developed a sense of purpose. Once the program ended however, with the loss of structure Patient once again felt like he had lost purpose. There were also interpersonal issues between Patient and his wife.

I did recommend that the patient get involved in other activities. We had discussed bow building which is something that I do and I gave him contact numbers for materials should he want to pursue this. I had also referred him to Mr. XX a physiotherapist with significant expertise in musculoskeletal injury. I note that Patient has always done taxing work in the past and he has minimal education and formal training. It was my opinion that it would be reasonable to refer him for vocational assessment and situational assessment to see what type of work he could manage.

The plan was to follow up with Patient through the clinic.

*Following the pain program Patient's function deteriorated. He has had minimal motivation to engage in activities. He recognizes what he has to do, but he has difficulty making himself do these things.*

***SECTION IV***

***This section is Dr. Ennis' formulation of the data contained in Section I, II, and III. A DSM V diagnosis is provided.***

**DIAGNOSIS:**

Axis I Somatic Symptom Disorder - predominantly pain

(ICD10-Persistent Somatoform Pain Disorder)

Major Depression

Social Phobia - mild.

Axis II Deferred

Axis III Patient meets criteria for fibromyalgia.

*These criteria have recently been revised. The revision no longer requires the presence of typical tender points although it does require wide spread tenderness.*

*The diagnosis of fibromyalgia is best verified by an expert in physical medicine, soft tissue injuries.*

Central canal stenosis at L4-5 and L3-4 with indenting of the thecal sac at L5-S1. There is developmental narrowing of the central canal with short pedicals at L4-5 and superimposed on a broad based posterior disc protrusion.

Axis IV Patient continues to report stress related to not being able to work and not being able to do most of the things that he used to do in his own life.

Axis V Current GAF 50/100.

## Global Assessment of Functioning (GAF) Scale (DSM - IV Axis V)

**Note: The complete GAF scale on page 32 of the DSM - IV and should be consulted for clinical use.**

| Code | Description of Functioning |
|---|---|
| **91 - 100** | Person has **no problems** OR has superior functioning in several areas OR is admired and sought after by others due to positive qualities |
| **81 - 90** | Person has **few or no symptoms**. Good functioning in several areas. No more than "everyday" problems or concerns. |
| **71 - 80** | Person has symptoms/problems, but they are **temporary, expectable reactions to stressors**. There is no more than slight impairment in any area of psychological functioning. |
| **61 - 70** | **Mild symptoms in one area** OR difficulty in one of the following: social, occupational, or school functioning. BUT, the person is generally functioning pretty well and has some meaningful interpersonal relationships. |
| **51 - 60** | **Moderate symptoms** OR moderate difficulty in one of the following: social, occupational, or school functioning. |
| **41 - 50** | **Serious symptoms** OR serious impairment in one of the following: social, occupational, or school functioning. |
| **31 - 40** | **Some impairment in reality testing** OR impairment in speech and communication OR serious impairment in several of the following: occupational or school functioning, interpersonal relationships, judgment, thinking, or mood. |
| **21 - 30** | **Presence of hallucinations or delusions which influence behavior** |
| **11 - 20** | There is **some danger of harm to self or others** |

**CONCLUSION:**

Patient is a 47-year-old man who was physically well prior to an accident that took place on xxxx/xx/xx. Since that time he has had significant problems with axial spine pain, unusual symptoms and generalized wide spread pain. On examination he does meet criteria for fibromyalgia.(See Appendix). The diagnosis of fibromyalgia no longer requires specific pain at designated tenderpoints. Widespread tenderness is a criteria. He does have control point tenderness which is a nonorganic finding.

On psychometric testing Patient is of average intelligence. Overall he feels 70% disabled. There is evidence of somatization, anxiety and depressed mood. A number of his scores suggest symptom exaggeration and a self perception of profound disability. His perception of his function is very low. There is evidence of catastrophic thinking, fear and avoidance and fear of movement. He perceives himself as bedbound as a result of axial spine pain.

In my opinion, Patient's symptoms meet criteria for a *somatic symptom disorder*. This is a new classification in the DSM V that replaces the old diagnosis of a pain disorder associated with both *psychological factors and a general medical condition* that was found in the DSM IV. The *somatic symptom disorder* no longer requires psychological factors as being central to the clinical presentation. However in the case of Patient there are significant psychological factors that are perpetuating his fear of health related problems. It is this disorder that in my opinion is the primary barrier preventing him from returning to his pre-accident level of function.

**Promoting Holistic Care-Somatic Symptom Disorder**

**The well-tested DSM-5 criteria for SSD remove overlap and confusion from previous editions and encourage comprehensive assessment of patients for accurate diagnoses and holistic care. The DSM-IV criteria included a large number of disorders that overlapped and made it difficult for primary care providers to effectively isolate the problem plaguing their patients. Because those suffering from SSD are primarily seen in general medical settings as opposed to psychiatric settings, the criteria in DSM-5 clarify confusing terms and reduce the number of disorders and sub-categories to make the criteria more useful to non-psychiatric care providers. To ensure that the new criteria would indeed help clinicians better identify individuals who need care; scientists tested the SSD criteria in actual clinical practices during the DSM-5 field trials. SSD's diagnostic reliability performed very well in these field tests.**

**Comprehensive assessment of patients requires the recognition that psychiatric problems often co-occur in patients with medical problems. While DSM-IV was organized centrally around the concept of medically unexplained symptoms, DSM-5 criteria instead emphasize the degree to which a patient's thoughts, feelings and behaviors about their somatic symptoms are disproportionate or excessive. The new narrative text for SSD notes that some patients with physical conditions such as heart disease or cancer will indeed experience disproportionate and excessive thoughts, feelings, and behaviors related to their illness, and that these individuals may qualify for a diagnosis of SSD. This in turn may enable them to access treatment for these symptoms. In this sense, SSD is like depression; it can occur in the context of a serious medical illness. It requires clinical training, experience and judgment based on guidance such as that contained in the DSM-5 text to recognize when a patient's thoughts feelings and behaviors are indicative of a mental disorder that can benefit from focussed treatment.**
**This change in emphasis removes the mind-body separation implied in DSM-IV and encourages clinicians to make a comprehensive assessment and use clinical judgment rather than a check list that may arbitrarily disqualify many people who are suffering with both SSD and another medical diagnosis from getting the help they need.**

## Somatic Symptom Disorder 300.82 (F45.1)

A One or more somatic symptoms that are distressing or result in significant disruption of daily life.

B Excessive thoughts, feelings, or behaviours related to the somatic symptoms of associated health concerns as manifested by at least one of the following:

1 Disproportionate and persistent thoughts about the seriousness of one's symptoms.
2 Persistently high level of anxiety about health or symptoms.
3 Excessive time and energy devoted to these symptoms or health concerns.

C Although any one somatic symptom may not be continuously present, the state of being symptomatic is persistent (typically more than 6 months).

**Specify if**:

With predominant pain (previously pain disorder): This specifier is for individuals whose somatic symptoms predominantly involve pain.

**Specify if:**

Persistent: A persistent course is characterized by severe symptoms, marked impairment, and long duration (more than 6 months).

**Specify current severity:**

**Mild:** Only one of the symptoms specified in Criterion B is fullfilled.
**Moderate:** Two or more of the symptoms specificied in Criterion B are fulfilled.
**Severe:** Two or more of the symptoms specified in Criterion B are fulfilled, plus there are multiple somatic complaints (or one very severe somatic symptom).

Under the ICD 10 Patient's symptoms meet criteria for a persistent somatoform disorder.

**ICD-10 F45.4 Persistent somatoform pain disorder**

The predominant complaint is of persistent, severe, and distressing pain, which cannot be explained fully by a physiological process or a physical disorder. Pain occurs in association with emotional conflict or psychosocial problems that are sufficient to allow the conclusion that they are the main causative influences. The result is usually a marked increase in support and attention, either personal or medical. Pain presumed to be of psychogenic origin occurring during the course of depressive disorder or schizophrenia should not be included here. Pain due to known or inferred psychophysiological mechanisms such as muscle tension pain or migraine, but still believed to have a psychogeniccause, should be coded by the use of F54 (psychological or behavioural factors associated with disorders or diseases classified elsewhere) plus an additional code from elsewhere in ICD-10 (e.g. migraine, G43.-).

Includes: psychalgia

psychogenic backache or headache

somatoform pain disorder

Differential diagnosis. The commonest problem is to differentiate this disorder from the histrionic elaboration of organically caused pain. Patients with organic pain for whom a definite physical diagnosis has not yet been reached may easily become frightened or resentful, with resulting attention-seeking behaviour. A variety of aches and pains are common in somatization disorders but are not so persistent or so dominant over the other complaints.

Excludes: backache NOS (M54.9)
pain NOS (acute/chronic) (R52.-)
tension-type headache (G44.2)

The primary barrier to function includes pain in excess of what would be expected given the nature of this patient's injuries, a concern about personal health and disability associated with an avoidance of activity for fear of further disability.

There is no evidence that Patient had a somatoform disorder prior to the index accident. In my opinion and on the balance of probabilities, the index accident made a material contribution to the onset of this disorder.

Co-morbid with the somatic/pain disorder is evidence of a *major depression.* Patients

with chronic pain are at high risk for the development of chronic pain.

**Major Depressive Disorder** 296.21 - 296.30 (F32.0 - F33.9)

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning: at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

**Note**: Do not include symptoms that are clearly attributable to another medical condition.

1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty, hopeless) or observation made by others (e.g., appears tearful). **Note:** In children and adolescents, can be irritable mood).
2. Markedly diminished interest in pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation).
3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day.
(Note: In children, consider failure to make expected weight gain.)
5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).
6. Fatigue or loss or energy nearly every day.
7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).
8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).
9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The episode is not attributable to the physiological effects of a substance or to another medical condition.

**Note:** Criteria A-C represent a major depressive episode.
**Note:** Responses to a significant loss (e.g., bereavement, financial ruin, losses from a natural disaster, a serious medical illness or disability) may include the feelings of intense sadness, rumination about the loss, insomnia, poor appetite, and weight loss noted in Criterion A, which may resemble a depressive episode. Although such symptoms may be understandable or considered appropriate to the loss, the presence of a major depressive episode in addition to the normal response to a significant loss should also be carefully considered. This decision inevitably requires the exercise of clinical judgment based on the individual's history and the cultural norms for the expression of distress in the context of the loss.

D. The occurrence of the major depressive episode is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified and unspecified schizophrenia spectrum and other psychotic disorders.

E. There has never been a manic episode or a hypomanic episode.
Note: This exclusion does note apply if all of the manic-like or hypomanic-like episodes are substance-induced or are attributable to the physiological effects of another medical condition.

There is no evidence that Patient had a mood disorder prior to the index accident. In my opinion and on the balance of probabilities, the index accident made a material

contribution to the onset of this disorder.

In regards to the assessment questions,

**1. What symptoms are noted upon examination?**

As described above.

**2. What are the results of the examination?**

As described above.

**3. What is your diagnosis?**

Axis I Somatic Symptom Disorder - predominantly pain

(ICD10-Persistent Somatoform Pain Disorder)

Major Depression

Social Phobia - mild.

Axis II Deferred

Axis III Patient meets criteria for fibromyalgia.

*These criteria have recently been revised. The revision no longer requires the presence of typical tender points although it does require wide spread tenderness.*

*The diagnosis of fibromyalgia is best verified by an expert in physical medicine, soft tissue injuries.*

Central canal stenosis at L4-5 and L3-4 with indenting of the thecal sac at L5-S1. There is developmental narrowing of the central canal with short pedicals at L4-5 and superimposed on a broad based posterior disc protrusion.

Axis IV Patient continues to report stress related to not being able to work and not being able to do most of the things that he used to do in his own life.

Axis V Current GAF 50/100.

**4. What, if any, contribution did the motor vehicle accident of April 3rd, 2009 have towards Patient's present condition?**

In my opinion the index accident made a material contribution to the onset of the *somatic symptom disorder* and *major depression.*

**5. This action is governed by Section 4.2 of Ontario Regulation 461/96 as amended by Ontario Regulation 381/03. I enclose a copy of this section. Could you please comment on the following:**

**(a) Whether the impairment:**

**I. substantially interferes with Patient's ability to continue on his regular or usual employment despite reasonable efforts to accommodate Patient's impairment and Patient's reasonable efforts to use the accommodation.**

In my opinion Patient's impairments do interfere with his ability to continue on his regular or usual employment despite reasonable efforts to accommodate Patient's impairment and Patient's reasonable efforts to use the accommodation. The primary barrier impairing Patient's ability to return to work is his perception of pain of perception of disability.

**ii. substantially interferes with Patient's ability to continue training for a career, or**

In my opinion Patient's impairment substantially interferes with his ability to continue training for a career. He is unable to tolerate the physical activity associated with work.

**iii. substantially interferes with most of the usual activities of daily living considering Patient's age**

In my opinion Patient's impairments interfere with his usual activities of daily living. His perception of pain and disability are such that he is avoidant of most activities.

**in accordance with Part 1 of Section 4.2(1) 1.**

**(b) Whether the function that is impaired is an important one in accordance with Section 4.2 (1) 2 and,**

In my opinion the function that is impaired is an important one. A patient's perception of themselves as healthy and intact is central to the vast majority of activities in day to day life. The nature of the somatoform disorder is that Patient no longer perceives himself to be healthy and capable of normal activity.

**(c) Whether the impairment is permanent within the meaning of Section 4.2 (1)3.**

In my opinion this impairment is permanent. Patient has been symptomatic since 2009. He has received optimum treatment without significant response. The end result is that the impairment is permanent.

**6. Your assessment of whether the current complaints or any complaints attributable to this accident, have or currently interfere or will in the future interfere with Patient's employment duties or future plans.**

As noted above, in my opinion Patient's psychiatric problems will interfere with his capacity to engage in any form of employment now and in the foreseeable future.

**7. Your assessment of whether the current complaints have or currently interfere or will in the future interfere with Patient's ability to undertake housekeeping and home maintenance tasks.**

In my opinion Patient's current complaints do interfere with his capacity to undertake housekeeping and home maintenance tasks. However, the patient will not be harmed by engaging in these activities. The barrier is his perception

of pain and disability. Therefore, the patient should be encouraged to engage in these activities.

It is recognized that even with encouragement it is highly likely that Patient will continue to avoid these activities. Providing housekeeping and home maintenance support becomes necessary because necessary tasks will not be completed. At the same time, such support can inadvertently reinforce the patient's beliefs about his level of disability. Therefore a balance must be found. This is best accomplished by providing housekeeping and home maintenance support under the supervision of an occupational therapist with some expertise in working with patients with chronic noncancer pain.

**8. Your assessment of any reasonable treatment required or likely to be required in the future as a result of the complaints attributable to the accident.**

1. I have sent Patient for testosterone levels with copies to be sent to Dr. XX. Opioids can suppress testosterone and this could account for the patients reduced libido and fatigue.

2. I have made a direct referral of Patient to Dr. XX at the Sleep Disorders Clinic. In my opinion this patient likely has significant sleep apnea that has been untreated. This puts him at risk for right sided heart failure. It can also account for headaches and fatigue.

3. Patient has been provided with optimum treatment. He should continue to be encouraged to increase his level of function. Should Patient increase his level of motivation, it would be in his best interest to participate in a tai chi program, exercise program or an aquatherapy program. He might also benefit from involvement in a hypnotherapy training program for pain control in order to help reduce his reliance on medication.

4. Patient is being treated with opioids. In my opinion this treatment should continue if it is associated with improved function only.

**9. What is your prognosis?**

In my opinion the prognosis for symptom reduction is poor. Patient has been symptomatic since 2009 and he had not responded to optimum care. The same is true of improved function. The prognosis is poor. Patient's level of function has been impaired since the accident of 2009. In fact, it has deteriorated over the course of time which is not typical of an organic injury. This is more in keeping with a somatization disorder. His function has not improved with treatment.

**10. What impact have the injuries from the motor vehicle accident of xxxx/xx/xx, had on Patient's past and future earning capacity and whether this will have any impact on his work life expectancy?**

In my opinion the index accident precipitated the onset of a somatic symptom disorder (persistent somatoform pain disorder) and major depression. As a result, Patient's earning capacity was negatively affected from the point of the accident. It is unlikely that he will return to work at any time in the future.

**11. Your assessment of whether Patient suffers a complete inability to engage in any employment or self-employments for which he is reasonably suited by education, training or experience.**

As stated previously, in my opinion Patient suffers a complete inability to engage in any employment or self-employments for which he is reasonably suited by education, training or experience. The primary barrier to function and employment is his perception of pain and disability.

**12. Finally, I have been asked to provide a catastrophic assessment of Patient.**

**Catastrophic Determination-Mental and Behavioural Disorders Impairment**

"Catastrophic Impairment", for the purposes of the Insurance Act and the Statutory Accident Benefits Schedule, with respect to motor vehicle accidents occurring on or after November 1, 1996, means...

> (g) any impairment that results in a class 4 impairment (marked impairment) or class 5 impairment (extreme impairment) due to mental or behavioural disorder, in accordance with the A.M.A. Guide.

The assessment for Catastrophic impairment considers the following categories:

- Self care and personal hygiene (Table 7.1)
- Social functioning (relationships) (Table 7.4)
- Deterioration or decompensation in work or work-like settings
- Concentration, persistence and pace (Table 7.5)

A. Self Care and Personal Hygiene.

Patient is capable of his own self care although there are days when he will pay less attention to these needs. He associates this with feeling unwell. In order to determine a rating of impairment, the following criteria will be used:

**Psychiatric Impairment Rating Scale-Self care and personal hygiene**

Class 1-No deficit, or minor deficit attributable to normal variation in the general population.

Class 2-Mild impairment. Able to live independently and look after self adequately, although may look unkempt occasionally. Sometimes misses a meal or relies on take-away food.

Class 3-Moderate impairment. Cannot live independently without regular support. Needs prompting to shower daily and wear clean clothes. Cannot prepare own meals, frequently misses meals. Family member or community nurse visits (or should visit) 2-3 times per week to ensure minimum level of hygiene and nutrition.

Class 4-Severe impairment. Needs supervised residential care. If unsupervised, may accidentally or purposefully hurt self.

Class 5-Totally impaired. Needs assistance with basic functions, such as feeding and toileting.

In my opinion Patient meets criteria for class 2 or mild impairment in this category.

B. Social Function (Relationships)

Patient's social activities have reduced. In part this is because Patient made a significant change in his life-style prior to the accident when he left his motorcycle group. He did this in order to change the direction of his life. Associated with the accident has been a reduction in social activity. The primary limiting factor is Patient's self-perception of pain and disability. Changes associated with the accident has resulted in stress between Patient and his wife resulting in disagreements.

**Psychiatric Impairment Rating Scale-Social functioning**

Class 1-No deficit, or minor deficit attributable to normal variation in the general population. No difficulty in forming and sustaining relationships, e.g. partner, close friendships lasting years.

Class 2-Mild impairment. Existing relationships strained. Tension and arguments with partner or close family member, loss of some friendships.

Class 3-Moderate impairment. Previously established relationships severely strained, evidenced for example by periods of separation or domestic violence. Partner, relatives or community services looking after children.

Class 4-Severe impairment. Unable to form or sustain long term relationships. Pre-existing relationships ended, e.g. lost partner, close friends. Unable to care for dependants, e.g. own children, elderly parent.

Class 5-Totally impaired. Unable to function within society. Living away from populated areas, actively avoids social contact.

In my opinion the level of impairment in this category is class 2 or mild impairment.

C. Deterioration or decompensation in work or work-like settings.

Patient has been unable to return to work since the accident. Prior to the accident Patient drove a truck that picked up rendered materials from restaurants. It was a demanding job. He would work in excess of 60 hours per week. The barrier to return to work has been the patient's perception of pain and disability.

**Psychiatric Impairment Rating Scale-Adaptation**

Class 1-No deficit, or minor deficit attributable to normal variation in the general population. Able to work full time. Duties and performance are consistent with person's education and training. The person is able to cope with the normal demands of the job.

Class 2-Mild impairment. Able to work full time in a different environment. The duties require comparable skill and intellect. Can work in the same position, but no more than 20 hours per week e.g. no longer happy to work with specific persons, work in a specific location due to travel required.

Class 3-Moderate impairment. Cannot work at all in same position as previously. Can perform less than 20 hours per week in a different position, which requires less skill or is qualitatively different e.g. less stressful.

Class 4-Severe impairment. Cannot work more than one or two days at a time, less than twenty hours per fortnight. Pace is reduced, attendance is erratic.

Class 5-Totally impaired. Cannot work at all.

Patient is not able to work at all. Therefore the impairments meets criteria for a Class 5 (totally impaired) impairment.

D. Concentration Persistence and Pace:

Patient's level of concentration has been negatively affected by his perception of pain and disability. He reported that he has difficulty reading for extended periods of time. However, he is capable of following a set of instructions. There is no obvious evidence of cognitive impairment during my assessment of the patient.

**Psychiatric Impairment Rating Scale-Concentration, persistence and pace**

Class 1-No deficit, or minor deficit attributable to normal variation in the general population. Able to operate at previous educational level e.g. pass a TAFE (technical and further education course) or university course within normal time frame

.

Class 2-Mild impairment. Can undertake a basic retraining course, or a standard course at a slower pace. Can focus on intellectually demanding tasks for up to thirty minutes e.g. then feels fatigued or develops headache

.

Class 3-Moderate impairment. Unable to read more than newspaper articles. Finds it difficult to follow complex instructions, e.g. operating manuals, building plans, make significant repairs to motor vehicle, type detailed documents, follow a pattern for making clothes, tapestry or knitting.

Class 4-Severe impairment. Can only read a few lines before losing concentration. Difficulties following simple instructions. Concentration deficits obvious even during brief conversation. Unable to live alone, or needs regular assistance from relatives or community services.

Class 5-Totally impaired. Needs constant supervision and assistance within an institutional setting.

In my opinion Patient's level of impairment in this category is Class 3 or moderate.

**Conclusion:**

Patient's impairment meets class 5 or total impairment as a result of his psychiatric problems in the area of 'deterioration or decompensation in work or work-like settings'. Therefore, his presentation meets criteria for a catastrophic designation.

**“Acknowledgment of Expert’s Duty” states:**

1. *My name is Dr. XX. I live in Hamilton, Ontario Canada.*

2. *I have been engaged by or on behalf of Patient (name of party/parties) to provide evidence in relation to the above-noted court proceeding.*

3. *I acknowledge that it is my duty to provide evidence in relation to this proceeding as follows:*
   - *( a ) to provide opinion evidence that is fair, objective and non-partisan’*
   - *( b ) to provide opinion evidence that is related only to matters that are within my area of expertise; and*
   - *( c ) to provide such additional assistance as the court may reasonably require, to determine a matter in issue.*

4. *I acknowledge that the duty referred to above prevails over any obligation which I may owe to any party by whom or on whose behalf I have engaged.*

*July 2, 2013*

| | |
|---|---|
| *Date* | *Signature* |

**OPINION OF THE EXAMINER:**

The opinions expressed in this report are based upon the examination(s), interviews, records and/or reports described above. They are based upon the subjective complaints and history provided to the examiner, the medical records and tests provided and the physical findings. It is assumed that the material provided is correct. The author reserves the right to alter an expressed opinion, to modify, and/or amend this report should further information come to light which would warrant reconsideration of our opinion. The opinions expressed in this report have been rendered independent of the requesting party and are based upon our professional assessment. This report is not to be copied, distributed or used by other than the requesting party without the consent of the author.

J.H. Ennis, MSW MD FRCP (C)
Evaluating Psychiatrist

JHE:sac
June 25, 2013