

**Financial Services  
Commission  
of Ontario**

**Commission des  
services financiers  
de l'Ontario**



**FSCO A05-000507**

**BETWEEN:**

**VERONICA TOURNAY**

**Applicant**

**and**

**DOMINION OF CANADA GENERAL INSURANCE COMPANY**

**Insurer**

**REASONS FOR DECISION**

**Before:** Robert A. Kominar

**Heard:** November 14, 15, 2005, in Hamilton, Ontario.

**Appearances:** Robert J. Hooper for Ms. Tournay  
Christopher J. Schnarr for Dominion of Canada General Insurance  
Company

**Issues:**

The Applicant, Veronica Tournay, was injured in a motor vehicle accident on March 12, 2003. She applied for and received statutory accident benefits from Dominion of Canada General Insurance Company ("Dominion"), payable under the *Schedule*.<sup>1</sup> Ms. Tournay applied for a catastrophic impairment designation as a result of this accident. The parties were unable to resolve their dispute through mediation, and Ms. Tournay applied for arbitration at the Financial Services Commission of Ontario under the *Insurance Act*, R.S.O. 1990, c.I.8, as amended.

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<sup>1</sup>The *Statutory Accident Benefits Schedule — Accidents on or after November 1, 1996*, Ontario Regulation 403/96, as amended.

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The issues in this hearing are:

1. Was Ms. Tournay catastrophically impaired as a result of the accident on March 12, 2003?

**Result:**

1. Ms. Tournay was catastrophically impaired as a result of the accident on March 12, 2003.

**EVIDENCE:**

Veronica Tournay has no recollection of the motor vehicle accident in which she was involved on March 12, 2003. Her independent memory begins after her return home from hospital, and all that she knows now about the accident has been related to her by others.

The accident occurred while Ms. Tournay was driving. She was accompanied by her daughter Allison, who is presently a high school student. Allison recalls only that she and her mother were going out for food - after that things become a blur. She, however, does recall seeing her seriously injured mother after the crash and that she tried to wake her up by grabbing at her arm and shaking her for approximately 10 minutes. Her mother was not responding to Allison's actions or voice and she was afraid that her mother had died.

Ms. Tournay suffered indisputably serious injuries in this accident. Her right leg was crushed under part of her vehicle. She had an obvious open fracture of her foot and large laceration on her right thigh, so deep that the bone was visibly exposed. She experienced severe pain resulting from her injuries. Both parties to this arbitration agree that Ms. Tournay suffered a traumatic brain injury in the accident.

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The issue in this arbitration is whether Ms. Tournay can be designated as “catastrophically impaired,” as defined in the *Schedule*. Dominion acknowledges the severity of her injuries. The dispute here relates to how the events which occurred after Ms. Tournay came into the care of the paramedics and medical staff who treated her impact on the legal interpretation of the term “catastrophic.” Counsel for both parties agree that this is an issue of law which in no way reflects on either the quality of care provided, or the appropriateness of the clinical decisions made by those who provided medical care for Ms. Tournay after the accident.

The parties acknowledge that Ms. Tournay is claiming entitlement to a catastrophic designation pursuant to section 2 (1.1) (e) (i) of the *Schedule*, which defines catastrophic impairment as follows:

- 2.(1.1) For the purposes of this Regulation, a catastrophic impairment caused by an accident that occurs before October 1, 2003 is,
  - (a) paraplegia or quadriplegia;
  - (b) the amputation or other impairment causing the total and permanent loss of use of both arms;
  - (c) the amputation or other impairment causing the total and permanent loss of use of both an arm and a leg;
  - (d) the total loss of vision in both eyes;
  - (e) brain impairment that, in respect of an accident, results in,
    - (i) a score of 9 or less on the Glasgow Coma Scale, as published in Jennett, B. and Teasdale, G., *Management of Head Injuries*, Contemporary Neurology Series, Volume 20, F.A. Davis Company, Philadelphia, 1981, according to a test administered within a reasonable period of time after the accident by a person trained for that purpose, or

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- (ii) a score of 2 (vegetative) or 3 (severe disability) on the Glasgow Outcome Scale, as published in Jennett, B. and Bond, M., *Assessment of Outcome After Severe Brain Damage*, *Lancet* i:480, 1975, according to a test administered more than six months after the accident by a person trained for that purpose;
- (f) subject to subsections (2) and (3), an impairment or combination of impairments that, in accordance with the American Medical Association's Guides to the Evaluation of Permanent Impairment, 4th edition, 1993, results in 55 per cent or more impairment of the whole person; or
- (g) subject to subsections (2) and (3), an impairment that, in accordance with the American Medical Association's Guides to the Evaluation of Permanent Impairment, 4th edition, 1993, results in a class 4 impairment (marked impairment) or class 5 impairment (extreme impairment) due to mental or behavioural disorder. O. Reg. 281/03, s. 1 (5); O. Reg. 314/05, s. 1 (1, 2).

Ms. Tournay claims that she meets the criteria for catastrophic impairment set out in subsection 2(1.1)(e)(i) of the *Schedule*, in that she suffered a brain impairment in the accident which resulted in her registering a Glasgow Coma Score (GCS) of 9 or less, in a test taken within a reasonable time after her accident. Dominion's position is that, because Ms. Tournay was intubated in the emergency room, any GCS score recorded while she was in that condition was, by definition, invalid and cannot be used to support a catastrophic impairment designation.

The Glasgow Coma Scale was developed by Dr. Graham Teasdale and Dr. Bryan Jennett and first published in 1974 in *The Lancet*<sup>2</sup> as an intersubjectively reliable, yet simple to use, clinical tool for the assessment of the "the depth and duration of impaired consciousness and coma" in patients. Jennett's and Teasdale's original article describing the GCS scale did not include the assignment of numerical scores to the levels of behavioral response which the test measures. This feature of the GCS was added in a subsequent text published in 1981, *The Management of Head Injuries*, and it is this text which is specifically referenced in the *Schedule's* definition of

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<sup>2</sup>Graham Teasdale and Bryan Jennet, "Assessment of Coma and Impaired Consciousness," *The Lancet*, July 13, 1974, pp. 81-83.

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catastrophic impairment. The primary purpose of adding numerical scoring, according to Dr. Jennett, is to “facilitate communication between doctors.” However the GCS has also developed into a method for correlating levels of consciousness with ultimate patient outcomes. It is this correlation with patient outcomes that likely explains why the *Schedule* sets the threshold for catastrophic impairment at “9 or less.” Dr. Jennett states:

Beyond the field of care of [head injured] patients the GCS has been used to classify head injured patients in epidemiological studies worldwide. Three grades of severity are recognized, severe (GCS 8 or less), moderate (GCS 9-12), and mild (GCS 13-15). These show, for example, that only 5% of admitted head injuries are severe in developed countries, while over 80% are mild. This has resulted in increasing interest in mild injuries because they are so frequent and because a substantial number of them develop complications resulting in death or disability. It is therefore important to consider the different prognostic features of patients assessed as GCS, 13,14, and 15 ... It is important not to assume that because a patient is classified as only mildly injured he has not suffered any brain damage.<sup>3</sup>

The GCS score is an additive function of independent observations made of a patient’s graded responses within three behavioral domains: eye movement, motor response and verbal response.

It is numerically scored according to the following criteria:

**Eye Opening**

4. Spontaneous, indicates arousal, not necessarily awareness
3. To speech. When spoken to- not necessarily the command to open eyes
2. To pain. Applied to limbs, not face where grimacing can cause closure.
1. None

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<sup>3</sup> See Bryan Jennett, “Development of Glasgow Coma and Outcome Scales” 2 *Nepal Journal of Neuroscience* (2005) pp 24-28, at p. 25.

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**Motor Response**

6. Obeys commands. Exclude grasp reflex or postural adjustments
5. Localizes. Other limb moves to site of nail-bed pressure
4. Withdraws. Normal flexion of elbow or knee to local painful stimulus
3. Abnormal flexion. Slow withdrawal with pronation of wrist, adduction of shoulder (decorticate posture)
2. Extensor response. Extension of elbow with pronation and adduction. (decerebrate)
1. No movement

**Verbal Response**

5. Orientated. Knows who, where, when; year, season, month
4. Confused conversation. Attends & responds but answers muddled/wrong.
3. Inappropriate words. Intelligible words but mostly expletives or random.
2. Incomprehensible speech. Moans and groans only – no words.
1. None

The maximum score one can be assigned is 15/15 and obviously the lowest is 3/15. Although the GCS was originally devised as a research tool, it soon became routinely accepted in clinical medical practice as a simple and reliable way of recording changes in a patient's level of consciousness. As noted above, it also is claimed by many to correlate well with patient outcomes following incidents of brain injury.

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In order to be classified as catastrophically impaired under the relevant section of the *Schedule*, one needs to score "9 or less" on a test administered by a qualified person within a reasonable period of time after the accident. Dominion accepts that Ms. Tournay suffered a traumatic brain impairment as a result of this motor vehicle accident. It also does not challenge the qualifications of any individual who administered GCS scores during her treatment after the accident. The sole issue before me is whether a GCS score recorded on an intubated patient is, in law, a "valid" GCS score.

**Dr. James Francis' Evidence**

Dr. Francis was the physician in charge of the emergency department at the time of Ms. Tournay's admission to McMaster University Medical Centre in Hamilton. He stated that he specifically remembered her case because his belief was that she had been triaged and transported to the wrong medical centre in Hamilton, as an adult suffering from multiple system traumas. It would have been appropriate, according to Dr. Francis, to triage a child suffering from multiple traumas to McMaster, but not an adult. The only explanation for the paramedics' decision to bring her to McMaster he had was that they likely decided to keep mother and daughter together.

Dr. Francis stated that Ms. Tournay was in his care for approximately 2 hours. She arrived at McMaster with a GCS score of 14-15 but her scores steadily declined over time. Ms. Tournay was becoming less aware of her surroundings and she was also becoming increasingly combative. Her level of consciousness was deteriorating according to Dr. Francis. Based on his observations, Dr. Francis determined that Ms. Tournay needed rapid sequence intubation. If this had not been done, there was a very real possibility that she would have lost her airway reflexes and ended up vomiting gastric contents into her airways. She also had an obvious open fracture of her foot as well as the possibility of other chest, abdominal and cervical spine injuries.

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She was clearly in a lot of pain and needed to be intubated for her own protection. Dr. Francis was adamant in his testimony that his decision to intubate Ms. Tournay was the proper medical decision, irrespective of its legal or insurance consequences, none of which concerned him while he was treating her. As I noted earlier, Dominion is not arguing in this arbitration that Dr. Francis' decision to intubate Ms. Tournay was anything other than medically proper.

### The Effect of Intubation

As described above, one of the three behavioural domains which the GCS monitors is verbal response. Jennett and Teasdale note that probably the most common marker of the end of coma and the restoration of consciousness is the uttering of understandable words, as it correlates strongly with a "restoration of a high degree of integration within the nervous system."<sup>4</sup> This probably corresponds with the average person's intuitions as well. However, since a GCS score includes observations of verbal responsiveness the definitional question arises as to whether one can "validly" make a GCS assessment when a patient is intubated, and therefore has had their verbal response purposefully restricted.

Dominion argues, relying on the evidence of Dr. Becker, who authored the Catastrophic Impairment Designated Assessment (CATDAC) Report, that it is impossible to conduct a valid GCS assessment and assign a standard numerical score on an intubated patient. The position of Ms. Tournay is that, notwithstanding Dr. Becker's opinions on how health care practitioners ought to use and record the GCS, the evidence here is that multiple GCS readings were taken throughout her treatment, including the period while she was intubated, and that some of them were scored at 9 or less. Thus, Mr. Hooper argues on behalf of Ms. Tournay, various health care professionals, whose qualifications to administer GCS tests is not disputed, took and continued to take GCS readings throughout a "reasonable period of time" after the accident, and some of those scores were "9 or less," bringing her within the *Schedule's* definition of catastrophic impairment.

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<sup>4</sup>Jennett and Teasdale, 1974, p 82.

**Dr. Becker's Evidence**

Dr. Becker was introduced as an individual who has had a long history with the DAC system in Ontario. He is primarily qualified as a family physician who also holds a doctorate in medical biophysics. He was involved with setting up and maintaining the Ontario DAC system from the beginning. Dr. Becker clearly has significant experience in conducting CATDACs and he has testified in numerous FSCO arbitrations. However, Dr. Becker's role in this arbitration was not to adjudicate the final decision, but rather to provide evidence which illuminated and supported the CATDAC conclusion, and Dominion's position, that Ms. Tournay was not catastrophically impaired. I note that Dr. Becker commented during his testimony about his perceived sense that others involved in this arbitration process were interested only in "splitting hairs." I do not draw any specific inference from these comments, other than that Dr. Becker clearly believes that the conclusion the CATDAC rendered in this matter is the correct one.

Dr. Becker's CATDAC report concluded in its *Executive Summary*:

While [Ms. Tournay] sustained a head injury and there is report of decreased consciousness at the scene, in fact, there has been no documented Glasgow Coma Score prior to intubation that would meet the threshold of "9 or less." There are numerous recordings of GCS *following* intubation but these readings are invalid with respect to interpretation of the Glasgow Coma Score as there would have been no score possible on verbal response. Therefore she will not meet the GCS (e)(i) criterion. (emphasis in the original)

Dr. Becker testified at the hearing:

"in my hands a GCS that is 9 or less that is going to the definition of catastrophic impairment should be - should have with it evidence of some form of brain injury."

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He noted that in this regard he had been trying for years to forge some consensus of professional opinion among CATDAC assessors on how to interpret the GCS as it relates to the *Schedule* with little success. In Dr. Becker's view "there is no direction [provided to assessors] in the *SABS*." Dr. Becker was asked by Mr. Schnarr during direct examination why he concluded that Ms. Tournay did not meet the definition of catastrophic impairment in the *SABS* and he responded that she never had a score of 9 or less, because her scores were all "confounded" by intubation and/or medication and the preparation for intubation. In Dr. Becker's view, any GCS score recorded while a patient is intubated is inherently invalid. Such scores would only be, in his words "sub-scores of 2 out of 3." Dr. Becker testified that he was certain that Ms. Tournay's verbal scores would be confounded but that it was also "possible" that her motor and eye scores might be confounded as well. After suggesting this possibility however, Dr. Becker provided no further evidence or opinion as to how intubation or medication might have "confounded" motor or eye movement GCS scores.

Dr. Becker was asked whether the administration of morphine and sedative drugs to Ms. Tournay had any impact on her neurological presentation. His response was that he did not know, but that he thought that it was a possibility. He was also asked why ambulance attendants and emergency room personnel administer GCS tests. As far as ambulance attendants go, his response was that it is just a normal part of their professional protocol; the inference being that they do it because they have been taught that it is one of the many things they are required to do if they are doing their jobs properly. When it comes to emergency room physicians, Dr. Becker testified that the GCS is helpful to physicians in monitoring a patient's loss of consciousness, which he stated can occur for multiple reasons.

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On cross examination Dr. Becker was asked to clarify whether Ms. Tournay had GCS readings of "9 or less" while in hospital after the accident. He acknowledged that there were in fact several readings in the hospital of "9 or less" but that these readings were all invalid because they were taken after intubation and thus "there would have been no score possible for a verbal response." When challenged on his interpretation of the GCS by Mr. Hooper, Dr. Becker acknowledged that it is impossible to receive a GCS score of zero in the verbal domain, as the lowest score possible is a 1; agreeing that even a dead person or a "table" could receive a 1 for a verbal GCS score. A GCS score of 1 is awarded to a patient who manifests absolutely no verbal response. Dr. Becker testified that he viewed this to be an "anomaly." He does not agree that it is reasonable to award 1 point for verbal response to someone who cannot respond at all. I take it to be a reasonable inference that, if Dr. Becker had developed the GCS system, it would be numerically scored differently than it actually is.

In continuing his testimony, Dr. Becker agreed with Mr. Hooper that his CATDAC Report only addressed the issue of the validity of the verbal element of Ms. Tournay's GCS scores while she was intubated. The Report raised no other issues about her entitlement to a catastrophic impairment designation under this section of the *Schedule*.

Dr. Becker further testified:

The fact is that Glasgow Coma Scores are invalid once a person is intubated. You can find all sorts of reasons why, but clearly the main reason is because they can't speak. I mean it's an obvious situation for those of us who work with Glasgow Coma Scores.

Mr. Hooper challenged him on the conclusion that these scores were "obviously" invalid by pointing out that the emergency room physicians, nurses and paramedic transport people continued to administer the GCS test and to record scores even after Ms. Tournay was intubated. Apparently the obviousness of the invalidity of such a practice was lost on these health care professionals. Dr. Becker's answer to this was [emphasis added]:

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*The implication is they are invalid for the purpose of catastrophic impairment reading. They are perfectly valid. They are valid for interpretations between emergency room staff in terms of whether the anaesthesia is holding, whether they are unconscious, whether they are coming up to a lighter level, whether they need more medication, as you can see, I'm not sure in this case, but they continue to give medication, usually [to] keep a person from becoming combative, or to allow them to manage them. The invalid reflects on the invalidity with respect to using this as a score under the e(i) criterion [of the SABS.]*

On further cross-examination, Dr. Becker was asked to clarify the basis for his opinion that the *Schedule* provided an exception to the definition of catastrophic impairment based on a GCS score of "9 or less" when a patient is intubated. The doctor, quite reluctantly, agreed with Mr. Hooper that the *Schedule* does not speak to the issue of GCS scores recorded on intubated patients. Notwithstanding this Dr. Becker continued to maintain that, if it is not possible to measure any one of the three scales, then a GCS is "not a GCS." Despite his adamant views on the matter Dr. Becker also testified that he "struggled" with knowing whether a GCS reading on an intubated patient was really a GCS score at all. Within the manifest frustration evidenced in this last comment I believe Dr. Becker was being bluntly honest about the interpretive challenges which the CATDAC assessors, and Dominion, faced in dealing with Ms. Tournay's case.

Dr. Becker continued his testimony by advising me that the "proper" way, in his view, to record a GCS score in the case of an intubated patient would be to record a numerical score out of 10, rather than 15, solely on the motor and eye scales, and then to append a "T" to that numeral to reflect that the patient was intubated at the time of the reading. Mr. Hooper presented the doctor with the hypothetical situation of a patient who was scored as a 1 on eye opening, a 1 on motor response, but was also intubated. Mr. Hooper suggested that, a GCS score for such a patient would, of necessity, be a number between 3 and 7, depending on what one recorded for verbal response - the minimum being a 1 and the maximum being a 5. Dr. Becker disagreed with Mr. Hooper's conclusion and stated that the proper score for such a patient was not in fact a number between 3 and 7, but rather "2T" as it was completely improper, in his opinion, to give

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an intubated patient "any" standard GCS score at all. Interestingly, Dr. Becker's comments confirm that GCS readings, at least in the motor and eye domains, remain a useful tool for physicians in monitoring the level of consciousness of an intubated patient. Dr. Becker's issue does not seem to be with taking GCS readings, but rather with how they are "recorded" and, more saliently, with what forensic use is ultimately made of those scores.

Mr. Hooper asked Dr. Becker whether he agreed that Ms. Tournay's level of consciousness was progressively deteriorating between the time she came into the care of the paramedics after the accident to the time she arrived in the emergency room at McMaster. He agreed that it was. He also agreed that it was important and proper for Dr. Francis to be concerned about her airway collapsing and to have intubated her at the time he did.

It was drawn to Dr. Becker's attention that Dr. Francis' emergency room notes recorded, and that he had testified, that Ms. Tournay was becoming "+ +" combative and increasingly respirate, and also that she had become oriented "times 1", whereas she had been oriented "times 3" in the ambulance. Dr. Becker agreed with Mr. Hooper that these observations all indicated a definite decline in Ms. Tournay's neurological functioning.

Mr. Hooper then directed Dr. Becker to a record which indicated that Ms. Tournay's GCS score had declined to 5. Dr. Becker acknowledged that at 11:00 p.m. on March 12, 2003, about 4 hours and 50 minutes after the accident, this was the recorded score for Ms. Tournay at Hamilton General Hospital, and that there was no "T" notation recorded, rather, a standard numerical GCS score of 5. This GCS test was conducted by Dr. Gregor, the emergency room trauma team leader at Hamilton General, the hospital where Dr. Francis stated that adult multiple system trauma patients were preferably to be directed to because of their expertise and facilities in such cases. Dr. Gregor assigned Ms. Tournay a score of 3 for motor response, a score of 1 on eye opening and a score of 1 on verbal response.

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Mr. Hooper's suggestion to Dr. Becker was that, given that his CATDAC Report stated that Ms. Tournay's GCS scores were invalid only within the verbal domain due to intubation, the only logical conclusion about her score at 11:00 p.m. on the night of the accident was that it was "9 or less." Even if one were to assume, for the sake of argument, that Ms. Tournay's verbal response at 11:00 p.m. might possibly have warranted a full GCS score of 5, meaning that she was fully oriented in all 3 spheres, the total GCS at that point in time could not arithmetically have added up to anything more than a total score of 9, i.e. ( 3 +1 + [5<sub>max</sub>]). Dr. Becker's response to this was that the question he was being asked to answer was "nonsense" and that he would in "no circumstances" validate any GCS score on any intubated patient. Quite defiantly, the doctor stated [emphasis added]:

Well let me get this clear. I am not validating a Glasgow Coma Score in a patient who is intubated. There is no such thing as a valid Glasgow Coma Score, that's my words, there is no such thing as a valid Glasgow Coma Score; okay? That is my answer to all of your questions, all of your hypotheticals, all of your specifics, on this case once the patient is intubated, and again just before that when the medication goes in to paralyze them and to sedate them the GCS does not work . . . *I don't care what the doctors have written, or what the nurses have written, it doesn't work.* This should have been a 4T, it was written incorrectly. *I am not going to validate another person's error in recording a GCS.*

Mr. Hooper asked Dr. Becker whether he could provide references to any documentation which supports his views on how to interpret or record GCS scores. Dr. Becker was unable to identify any such documentation.

**ANALYSIS**

Dominion accepts, and it is absolutely clear from the evidence, that Ms. Tournay did suffer a traumatic brain injury and a brain impairment as a result of this serious accident. She also registered declining GCS scores from the time she was seen by the paramedics to the time she was transported from McMaster to Hamilton General. Ms. Tournay was appropriately intubated by Dr. Francis. After intubation she was recorded as manifesting GCS scores of 3 and 5. On the face of these facts it seems that Ms. Tournay does qualify under the section 2(1.1)(e)(i) of the *Schedule* for a designation of catastrophic impairment.

The question which I have to answer however, is the one which clearly troubles Dr. Becker. Were Ms. Tournay's GCS scores recorded while she was intubated GCS scores within the meaning of the *Schedule*?

Dr. Becker's view is that there is a radical difference between GCS scores administered for medical purposes by qualified medical personnel going about their professional work, such as those who were treating Ms. Tournay, and GCS scores which are later being reviewed for the purpose of determining catastrophic impairment status under the *Schedule*. With all due respect to Dr. Becker's long experience in conducting CATDACs, I disagree. I find that there is no basis in law for any such distinction being made, given the language of the current regulation, and it is that language which governs my decision here. Whether or not it would be appropriate for the government to review this section of the *Schedule*, given the concerns raised by Dr. Becker about the challenges associated with assigning a GCS score to an intubated patient, the current reality is that just the opposite conclusion which Dr. Becker draws is the most warranted one.<sup>5</sup>

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<sup>5</sup>The government has in recent amendments to the *Schedule* dealt with an issue surrounding GCS scores for people under 16 years of age. It is noteworthy that they did not make any amendments to the definition of catastrophic in the case of intubated patients.

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The *Schedule*, in specifying the criterion for a catastrophic impairment determination under section 2(1.1)(e)(i), explicitly indexes the interpretation of the GCS score to the medical use of the test, as it is described in *The Management of Head Injuries*, by Dr. Jennett and Dr. Teasdale.<sup>6</sup> There is no distinct "legal" or "insurance," or "forensic" interpretation of the GCS apart from its articulation in this text. It is not intended to be administered in the manner of an insurer's examination by someone retained to give the insurance company an independent opinion on neurological function. The GCS is a clinical test pure and simple. Thus, if a medically appropriate GCS test registers a score of "9 or less" within a reasonable time after the accident, where the brain impairment as a result of the accident is not contested, then, in my view, that must be taken as satisfying section 2(1.1)(e)(i) of the *Schedule*. There is simply no further legal filter which the test needs to pass through to validate its results.

Dr. Francis was fully justified in emphasizing that his trauma team's concerns in treating Ms. Tournay were not related to whether she satisfied the criteria of some legal or insurance test. The purpose of their medical intervention, in this case, was to save Ms. Tournay's life and to help her recover from some very serious injuries. The last thing I would have expected to have been on Dr. Francis' mind, or that of any other health care practitioner attending to Ms. Tournay, was being a scrivener focused on recording clinical data in a legally desirable format. All of the GCS tests administered to Ms. Tournay were done solely for the purposes of providing the kinds of medical information which Dr. Becker clearly agreed that emergency room physicians find valuable in monitoring the neurological status of a patient. Although no specific GCS tests were recorded for Ms. Tournay just prior to intubation, Dr. Francis testified that it was her rapidly declining neurological condition which caused him to intubate her.

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<sup>6</sup>*Management of Head Injuries*, Contemporary Neurology Series, Volume 20, F.A. Davis Company, Philadelphia, 1981

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That being said, the facts before me in this arbitration are that the health care team involved in Ms. Tournay's care did take and did record a number of GCS readings during the time they treated her after the accident. These occurred within a period of approximately 4 hours, and I find that, due to the seriousness of her injuries, her declining neurological status, and the time it took to assess her and make appropriate treatment decisions, that this is within a reasonable time after the accident. Given that there is no dispute that Ms. Tournay suffered a brain injury in this accident, I find that there is more than sufficient reason to conclude that the scores taken during her period of emergency care were taken within a reasonable time. Beyond this, I note that Dominion did not offer evidence or argue in this arbitration that the GCS tests, if valid, were not conducted within a reasonable period of time after the accident.

Dr. Becker's stated opinion is that Dr. Francis' trauma team at McMaster made errors, in that what they ostensibly recorded as GCS scores were not "really" GCS scores at all, but at best scores on what he referred to as "sub-scales." Notwithstanding this Dr. Becker in cross examination acknowledged that, for medical purposes, in an emergency room, all of the GCS tests administered and recorded for Ms. Tournay were, in his own words, "perfectly valid."

When I weigh Dr. Becker's personal views on the proper use of the GCS against what I accept to be the routine use made of the GCS by those who treated Ms. Tournay in Hamilton, I am strongly persuaded that what happened in the ambulances and the hospitals is what should have happened and that Dr. Becker's views, although perhaps provocative on a theoretical and policy level, reflect an exception to the current standard medical practice, and that standard clinical practice is consistent with the GCS as described by Jennett and Teasdale, and therefore by necessary implication with the *Schedule* as it is currently worded.

As noted above, I disagree with Dr. Becker, that there is a special "SABS interpretation" of GCS scores, one which allows him to find that, notwithstanding the "perfect validity" of Ms. Tournay's scores for medical reasons, these same scores are "confounded" and "invalid" for purposes of the *Schedule*.

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The purpose of the catastrophic impairment designation in the *Schedule* is patently clear. In cases where an automobile accident causes very serious impairment to someone, the level of medical rehabilitation benefits they have access to is increased. There is an intentional direct proportionality between the scale of the injuries and the impairment someone suffers as a result of an accident and the level of benefits which they may be entitled to in order to facilitate their recovery. Who could reasonably argue with this? In order to qualify for these enhanced benefits, however, one has to fall within at least one of the multiple definitions of being catastrophically impaired as set out in the *Schedule*. It is clear that these definitions of catastrophic impairment are exclusively disjunctive; fitting under any one of them will qualify one for the designation. In this regard, I note that Dominion raised the possibility that Ms. Tournay might, at some future date, qualify under some other section. To my mind this is irrelevant in determining whether she falls under section 2(1.1)(e)(i). Whether one qualifies under only one or all of the sections of the definition makes no difference whatsoever.

In its wisdom, the Ontario government chose to identify those who record a GCS score of "9 or less," in a test administered within a reasonable time after the accident, as being catastrophically impaired. Dr. Becker states that, in his view, the section is problematic, as he believes that catastrophic status ought to be clearly tied to some manifestation of brain injury and not simply to impairment. He also noted that there was no consensus which he was ever able to generate among CATDAC assessors regarding interpretation. As noted above, Dr. Becker absolutely refused to acknowledge that Ms. Tournay could qualify as catastrophically impaired because she was intubated, yet he also admitted that the *Schedule* does not speak anywhere of exceptions to the validity of GCS tests administered by a qualified person on an intubated patient.

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The *Schedule* takes the rather uncommon legislative step of indexing this particular “test” of catastrophic impairment to a specific primary reference source, which is the text published by Dr. Jennett and Dr. Teasdale in 1981, *The Management of Head Injuries*. This text is therefore incorporated by reference into the *Schedule* and in my view it must currently be treated as authoritative in the interpretation of what a “valid” GCS score is. Although I was not specifically referred to this text by either counsel or by Dr. Becker, I searched it out myself, as the *Schedule* requires me to interpret GCS scores in accordance with the description of the GCS in that text.

Dr. Jennett and Dr. Teasdale, do not anywhere in *The Management of Head Injuries*, refer to Dr. Becker’s preferred method of recording the GCS score for intubated patients. The GCS score is the standard numerical score out of 15 only. But, even more importantly, Jennett and Teasdale make it clear that one of the explicit purposes for developing the GCS was to prevent neurological function from being described in terms of only one domain of response. All three aspects of behavioral response were to be assessed independently. They also explicitly recognize in their original 1974 article that the three domains of responses were needed, because one type of response, for various reasons, might be untestable.<sup>7</sup> Yet notwithstanding this proviso, that there may be occasions when you can’t test one of the domains, they continue to describe the GCS test and its usefulness without ever suggesting that it would be “confounded” or “invalid” in some cases. Jennett and Teasdale, in *The Management of Head Injuries*, specifically recognize the challenges associated with conducting a GSC test on an intubated patient, but *contra* Dr. Becker, not to say that one cannot validly conduct such a test. Rather they say:

Verbal response may be impossible because of the presence of an endotracheal tube, and young children or patients who have only a foreign tongue may remain silent when other aspects of behavior betray a higher level of responsiveness. Such absence of speech also occasionally occurs when there is total aphasia. *One of the advantages of this coma scale is that it allows responsiveness to be assessed even when some information is missing.* (Emphasis added)<sup>8</sup>

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<sup>7</sup> Ibid., p. 82.

<sup>8</sup> Ibid., pp. 80-81.

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Mr. Hooper noted, and it is salient in my view, that the accepted standard method of numerical scoring of the GCS, includes, in all 3 behavioral domains, the explicit possibility of “no response at all.” Dr. Becker regards the awarding of a score of 1 to someone who has no ability to speak, open their eyes, or move as being “anomalous.” Notwithstanding that this may be seem rather counterintuitive, the reality is that this is how the standard GCS, as described by Jennett and Teasdale, is recorded. You can be dead or a “table”, as Mr. Hooper noted, and still register a GCS score of 3.

Dominion did not argue that any of the GCS scores recorded on Ms. Tournay were done for inappropriate medical reasons, or by unqualified persons. Dr. Becker himself stated that the tests on Ms. Tournay would be perfectly valid from the perspective of health care professionals and would have provided Dr. Francis and his trauma team with valuable information about the changing state of consciousness of Ms. Tournay. The reality which the scores reflect, and the evidence before me, is that Ms. Tournay was undergoing a regularly declining state of consciousness while in the McMaster emergency room. Dr. Francis testified, and he was unchallenged in his evidence, that Ms. Tournay was becoming more combative, increasingly respirate and more incoherent, and that this behavior called for rapid sequence intubation to protect her life.

Upon transport to Hamilton General she was recorded as registering GCS scores of 3 and 5. Dr. Becker acknowledged that his conclusions about the validity of the GCS scores, as noted in his CATDAC Report, which he had time to carefully reflect on before writing, were that the “intubation” confounded her verbal scale. He did not testify and there is no other evidence before me, that he had formed any opinion that medication which had been administered to Ms. Tournay “confounded” her scores, although he did suggest in his testimony that it might have. Dominion presented no other evidence to that effect either. I note here that in his testimony Dr. Becker did acknowledge that he did not even know what one of the medications (Adomedita) administered to Ms. Tournay was. I find this to be significant support for the inference that Dr. Becker really did not believe that drugs were implicated in the problem he had with Ms. Tournay’s GCS

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scores, otherwise one would have reasonably expected him to have made inquiries into the nature and effects of the medication involved.

What then is the implication of intubation, or the artificial interference with Ms. Tournay's ability to speak due to a gastrointestinal tube being inserted into her throat? We know that she suffered a traumatic brain injury in this accident. We know that she was unconscious in the vehicle after the accident and that her daughter believed that she was dead when she could not shake her back into consciousness. We know that a score of 14 or 15 was recorded for her by the paramedics soon after they extricated her from her vehicle. We know that in the emergency room at McMaster she became increasingly combative and respiration and that she was in significant pain from her injuries. We also know that Dr. Francis stated that such observations caused him to have serious concerns about her rapidly declining neurological functioning and so he intubated her. We know thereafter that there were recorded GCS scores of 3 and 5 for Ms. Tournay within 4 hours after the accident.

The only plausible and reasonable inference to draw here is that Ms. Tournay was in a period of rapid neurological decline after this accident which resulted in her acknowledged brain injury and impairment. I find that the GCS scores registered here were "valid", in that I have nothing before me that would persuade me to agree with Dr. Becker that all of the medical professionals in Hamilton were incorrect in how they recorded GCS scores. And this conclusion is further supported by Dr. Becker's own evidence that the GCS scores were "perfectly valid" for medical purposes. If the scores, as recorded, were perfectly valid for medical purposes, then they are perfectly valid for purposes of the *Schedule*.

Dominion urged me to agree with Dr. Becker that the scores recorded while Ms. Tournay was intubated were "confounded" and therefore invalid. In my view, this can only mean in this case that they were unrecordable on the verbal scale, as Dr. Becker himself noted that he would have scored the 5 Ms. Tournay was awarded by Dr. Gregor as a 2T, therefore implicitly accepting the measurements recorded on the motor and eye movement scales. To be "confounded" in this case

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can only mean, according to Jennett and Teasdale, that some other number, between 2 and 5, should have been awarded to Ms. Tournay. Although Dr. Becker and Dominion may find this unpalatable, the reality is that Ms. Tournay's lack of verbal response after intubation still entitles her a minimum GCS score of 1. As Mr. Hooper argued, even if one assumes that she was "artificially" put into a state which caused her to be awarded a 1 for verbal response by the intubation procedure, the mathematical reality here is that, if one hypothetically adjusts the verbal score and awards her a 5 on the assumption that she might have been completely "orientated" - which is the criterion for getting a 5 on the verbal scale - the total achievable still is a maximum to a score of 9. Thus, even if one accepts Dr. Becker's concerns, there was no logical possibility of Ms. Tournay having scored more than 9 at that point in time. It is also reasonable to assume that Ms. Tournay would not have been awarded a 5 for verbal even without the tube, because that score calls for orientation in all 3 dimensions of: who she was, where she was, and when it was. The emergency room notes of Dr. Francis clearly state that Ms. Tournay, while originally orientated in all 3 spheres declined to orientation in 1 sphere only.

There is only one arbitration decision which deals with the implications of GCS scores recorded on intubated patients: *Young and Liberty Mutual Insurance Company*<sup>9</sup>, confirmed on appeal in *Liberty Mutual Insurance Company and Young*.<sup>10</sup> However, I find that the issue in *Young* is not the one which I have to determine in this case and also that it is distinguishable on the facts.

In *Young*, the Arbitrator was dealing with the issue of what a "reasonable time" after an accident means in the context of GCS testing. Specifically, the issue was how long one needed to maintain a GCS score of "9 or less" to qualify for a catastrophic impairment designation. Mr. Young recorded low GCS scores right after his automobile accident but they increased to a level about 9 within less than 6 hours, which was the time period which Liberty Mutual argued was necessary to qualify for a catastrophic impairment designation.

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<sup>9</sup>(FSCO A02-000695, November 14, 2003), p. 28

<sup>10</sup>Appeal (FSCO P03-00043, June 20, 2005)

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As I noted above, I find that *Young* is distinguishable on the facts from the present case. Ms. Tournay's clinical history was quite different from Mr. Young's, in that she first presented with relatively high GCS scores, which rapidly and continually declined throughout the next few hours.

From an interpretive point of view, I find the decision in *Young* to be consistent with my decision here that the GCS is explicitly a clinical test. The Arbitrator states:

I accept the Applicant's view that a GCS score is not intended to project into the future the medical status of an applicant, but is rather a tool employed among medical practitioners to communicate the level of consciousness of a person who has sustained head trauma.<sup>11</sup>

The Arbitrator goes on to observe that the *Schedule* provides other means of assessing catastrophic status at times further down the road.

In *Young* it appears that neither the hearing arbitrator nor the Director's Delegate was referred to Jennett and Teasdale's text, although in that case the relevance of their description of the GCS was not as squarely in issue as it is here.

Mr. Hooper also referred me to the case of *Holland and Pilot Insurance Company*.<sup>12</sup> In that case, Justice Keenan ruled that a GCS score of 4, recorded while Mr. Holland was apparently impaired by the ingestion of alcohol, was not an "invalid" score, as the current text of the *Schedule* does not contain any limitations restricting the use of the GCS. He states:

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<sup>11</sup> *Young and Liberty Mutual*, FSCO A02-000695, p 28.

<sup>12</sup> *Holland and Pilot Insurance Company*, 2004 CanL II 13787 ( Ontario Superior Court)

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The definition of ‘catastrophic impairment’ in the Statutory Accidents Benefits Schedule is a creature of the legislature. This type of regulation is adopted by the legislature after extensive consultation with interested parties, including insurers. If restrictive meaning is to be assigned to the regulation it should be clearly recited in the regulation itself.<sup>13</sup>

In conclusion, I reject Dr. Becker’s view that the GCS scores recorded for Ms. Tournay were “confounded” and thus invalid. I do this based on the clear evidence before me that the medical professionals at McMaster and Hamilton General continued to take and record GCS scores throughout her treatment. I also base my conclusion on Dr. Becker’s confirmation that what was done medically here was proper and that, for medical purposes, the GCS scores that were recorded were “perfectly valid.”

While I have some empathy with Dr. Becker and the challenges he, other CATDAC assessors and insurers have had in interpreting the *Schedule* at times, I find that he is incorrect in his view that there is some special “SABS” related interpretation of GCS scores, distinct from the normal day to day use which medical professionals trained in its administration make of it in ambulances and hospital emergency rooms. The government chose to stipulate, as Justice Keenan noted, that a GCS score of “9 or less,” as defined by Jennett and Teasdale, was a sufficient criterion for a designation of catastrophic impairment. If for some reason Dr. Becker’s views on who should be deemed catastrophically impaired are persuasive, it would require a regulatory change to enact them. Until such time as that occurs, I am required to make my decision based on the way the *Schedule* is currently drafted.

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<sup>13</sup> Ibid., p. 5.

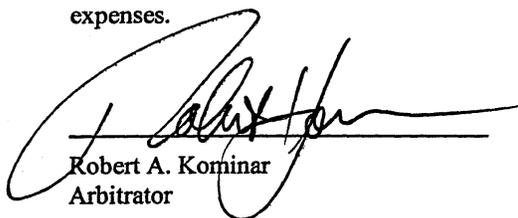
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Quite apart from the legal issues of statutory interpretation, it is clear to me in this case that there is no reason to disbelieve that Ms. Tournay is requesting this designation because she truly did suffer a significant brain impairment as a result of this accident. Her testimony, brief as it was, and that of her daughter, made it absolutely evident that her life has become seriously compromised due to these injuries. I doubt that being designated catastrophically impaired or not is a "hair splitting" matter for her. Surely a reasonable and balanced interpretation of the law does not contemplate that someone in Ms. Tournay's position should be denied a catastrophic impairment designation because she was so seriously injured in an accident that she required emergency intubation to preserve her life. I am not suggesting that everyone who is intubated is automatically entitled to a catastrophic designation, only that in this particular case, on the specific evidence before me, it is manifestly evident that, notwithstanding Ms. Tournay's intubation, she did register a valid GCS score of "9 or less" within a reasonable time after her automobile accident.

Therefore, I find that Ms. Tournay suffered a catastrophic impairment as a result of motor vehicle accident which occurred on March 12, 2003.

**EXPENSES**

The parties did not address the issue of expenses in the hearing. In the event that an agreement on expenses cannot be reached within 30 days of the release of these reasons an expenses hearing can be arranged with the Case Administrator. I shall determine the entitlement and quantum of expenses.

  
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Robert A. Kominar  
Arbitrator

July 20, 2006

\_\_\_\_\_  
Date

**Financial Services  
Commission  
of Ontario**

**Commission des  
services financiers  
de l'Ontario**



**FSCO A05-000507**

**BETWEEN:**

**VERONICA TOURNAY**

**Applicant**

**and**

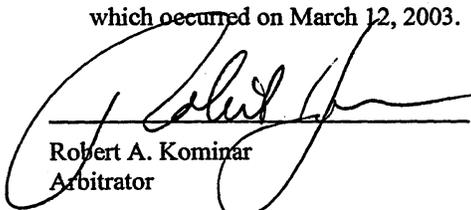
**DOMINION OF CANADA GENERAL INSURANCE COMPANY**

**Insurer**

**ARBITRATION ORDER**

Under section 282 of the *Insurance Act*, R.S.O. 1990, c.I.8, as amended, it is ordered that:

1. Veronica Tournay sustained a catastrophic impairment as a result of the automobile accident which occurred on March 12, 2003.

  
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Robert A. Kominar  
Arbitrator

July 20, 2006

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Date