Dost, Rehan – Neurologist

H.M. v Wawanesa Mutual Insurance Company, 2020 CanLII 61466 (ON LAT), <https://canlii.ca/t/j9fcg

[34] The same can be said for neurologist Dr. Rehan Dost who completed the IE neurological assessment report, dated June 26, 2018. I note that Dr. Dost does not appear to have reviewed the Job Site Analysis, which lists the essential tasks of the applicant's position and the heavy physical demand level required, as it is not referenced in the report or included in the list of documents reviewed. Further, Dr. Dost undertakes no discussion of the heavy physical demand level cited in the Job Site Analysis. I do not find convincing his conclusion that, from a neurological perspective, the applicant does not suffer a substantial inability to perform the essential tasks of his pre-accident employment.

[35] I also note that Dr. Dost confirms that, as a result of the accident, the applicant sustained an injury to his neck resulting in pain that radiates down his right arm with numbness and tingling. Specifically, Dr. Dost states that the applicant has a right C7 nerve root radiculopathy as he was positive in the Spurling test on the right and imaging of the cervical spine shows severe foraminal narrowing pre-existing at C6/C7 which would predispose into the development of the problem. Dr. Dost concluded it was related to the accident as the symptoms were immediate with the applicant reporting cervical pain within days of the accident that began radiating down the right arm roughly in the C7 area with tingling. Dr. Dost further opined that the applicant does have advanced degenerative change with severe foraminal narrowing in the cervical spine which would have predisposed him to this condition.

[36] Given the above, and based upon the totality of the evidence presented, I find that the applicant has established on a balance of the probabilities that he suffers a substantially inability to perform the essential tasks of his pre-accident employment. I find that he is unable to meet the heavy physical demand level of his pre-accident employment as a steel worker.

[38] The respondent points out that causation is an issue with respect to the applicant's headaches, low back pain and right leg radiculopathy. I do not find causation to be an issue.

[39] The respondent relies upon the IE neurology report of Dr. Dost who states that the applicant would not satisfy the criteria for any posttraumatic headache disorder as they began many months after the accident and would best be classified as chronic tension-type headache.

[40] With regards to the applicant's lower extremity symptoms, Dr. Dost opined that he likely has discogenic low back with right L5 root symptoms. However, this was not related to the accident as the right leg symptoms began spontaneously in January 2018 and the temporal lag is not compatible with traumatic causation. However, I note that Dr. Dost acknowledges that the applicant had lower back pain initially after the accident. The respondent also acknowledges that Dr. Dost opined that the applicant did suffer from a soft tissue injury to his lower back in the accident.

[41] I have considered Dr. Dost's opinion with regards to causation and found it unpersuasive. I note that the applicant's medical records reference headaches and low back symptoms immediately after the accident which have continued to date. On May 8, 2015, in his clinical notes and records, the applicant's family doctor, Dr. Patel, notes the applicant's headache symptoms and his complaints of lower back pain as well as some neck pain. A physiotherapy progress note, dated June 1, 2015, states the applicant reports facial numbness and lower back pain that is increasing but centralizing. In the Disability Certificate dated June 18, 2015, the applicant states that he has neck and low back pain. On December 21, 2015, Dr. Giammarco noted that the applicant reported immediate neck pain and headache after the accident.

Raedwulf v Kelly, 2020 BCSC 915 (CanLII), <https://canlii.ca/t/j8cg4

Dr. Rehan Dost

[80] According to Dr. Dost, a neurologist, Ms. Raedwulf does not demonstrate the requisite symptoms for a formal diagnosis of concussion/mild traumatic brain injury (MTBI) from either the first or second accident. He bases this opinion on two things: first, his review of the medical documentation did not reveal that Ms. Raedwulf suffered a loss of consciousness, confusion or disorientation following either accident; and second, in his opinion there are "far more plausible explanations" for her cognitive issues including the effects of pain and disturbed sleep. This is a significant distinction as cognitive difficulties caused by non-restorative sleep and psychological factors can show improvement with treatment. Cognitive difficulties caused by a concussion or MTBI will not. I will return to this.

[81] Dr. Dost is of the opinion that Ms. Raedwulf's headaches are chronic. They are attributable to whiplash from the first accident and exacerbated by the second. Dr. Dost opines that these headaches have not been "optimally treated" and are being perpetuated by "sleep alteration and psychological factors." Like Dr. Perera, Dr. Dost recommends the headaches be treated with Botox injections. However he testified that the injections cost between $500 and $750 per treatment and that treatments should be every three months as long as the injections are helping. Dr. Dost is unable to predict the response Ms. Raedwulf will have to this therapy.

[101] All experts but Dr. Dost take the position that Ms. Raedwulf suffered a head injury. If Ms. Raedwulf's symptoms are the result of a brain injury, then they are not treatable. If not, treatment may make a difference.

[102] As set out above, Dr. Dost concluded that it is a more plausible explanation that Ms. Raedwulf's cognitive symptoms are caused by lack of sleep and pain rather than a brain injury. He bases this opinion on the fact that he did not see mention in the medical records that Ms. Raedwulf suffered a loss of consciousness, confusion or disorientation immediately following the accidents. This is incorrect. Following the first accident the emergency room physician noted that Ms. Raedwulf complained of "mild head fogginess" and dizziness. Under diagnosis, the emergency room doctor noted, "? Concussion", and under discharge instructions entered "Head Injury sheet." Ms. Raedwulf described herself as stunned, confused, foggy headed. After the second accident she described herself as having brain fog and suffering mental confusion. In addition, when Ms. Raedwulf's sleep improved through the use of CBD oil, her symptoms persisted.

[103] Having considered all of the medical evidence, I prefer the opinion of the other medical experts to Dr. Dost's. I am satisfied that Ms. Raedwulf suffered a mild traumatic brain injury in the accidents.

Windsor v Cawley, 2020 BCSC 678 (CanLII), <https://canlii.ca/t/j6whd

[44] Dr. Rehan Dost is a neurologist who completed an independent medical assessment of the plaintiff in February 2019. Dr. Dost opined that the plaintiff did not suffer a brain injury of any severity in any of the collisions. He felt that the plaintiff's cognitive issues are a result of pain, as well as an underlying psychiatric disorder.

[45] I have considerable difficulty with the evidence of Dr. Dost. He admitted that he spent only 40 minutes with the plaintiff. Though there are numerous documents listed as reviewed by him in an appendix to his report, they are not referenced in any portion of his report. He did not appear to be aware of her part-time employment between the First and Third Collisions, organized with the assistance of an occupational therapist. As noted by counsel for the plaintiff in their submissions and, as put to Dr. Dost in his cross-examination, numerous judges of this court have commented on Dr. Dost. Others have been critical of his lack of attention of a patient's history of symptoms, the little time he spends with a plaintiff, not having accessed a full clinical history, a troubling lack of depth in his analysis, and the superficiality of his report.

[46] Dr. Dost stated, based on his 40-minute assessment of the plaintiff, that she is independent of basic activities of daily living. That is not consistent with any other evidence. Although he noted in his list of documents reviewed the cost of future care

report of Sharyle Jewett, he did not appear to consider the summary of assessment findings in that report, including the notation that the plaintiff requires reminding for showering, shampooing and brushing her teeth. It seems clear that Dr. Dost did not review that report in anything other than a summary way. Much of Dr. Dost's report seems to be conjecture, seems to be based on his clinical experience and his seemingly momentary observations from the 40-minute examination. This is particularly concerning about the plaintiff's noted stuttering and word finding difficulties. The factual evidence before me is that this was not something that the plaintiff suffered from prior to any of the collisions. Dr. Dost claimed that these difficulties are "non-organic". By "non-organic," he means as not related to structural brain damage, but instead are subconscious. How that determination can be made based on a 40-minute assessment, a superficial review of medical reports, no attempt to draw from any of the medical evidence or from any collaterals the condition of this plaintiff immediately prior to the accident, is not only disconcerting, but fatal to any reliance on his subsequent opinion. I place no weight on the opinion of Dr. Dost. He has, in the Supreme Court of British Columbia, been regularly criticized for the superficial nature of his reports. I find the report he prepared in this case to be of a similar nature.

Gauthier v Dubois, 2018 BCSC 229 (CanLII), <https://canlii.ca/t/hqgp7

[91] In his rebuttal report, Dr. Cameron accepted that the treatment records suggest that Mr. Gauthier probably reported that he had not experienced a loss of consciousness in the minutes and hours following the accident. This does not mean, however, that Mr. Gauthier had not in fact lost consciousness before then. In any event, like Dr. Filbey, he noted that a gap in memory too can be diagnostic of a mild traumatic brain injury. Like Dr. Filbey, he noted that an MRI will not necessarily detect a mild traumatic brain injury. He denied that he failed to consider alternative explanations or that he relied exclusively on Mr. Gauthier's self-reported gap in memory to found his diagnosis of MTBI. On the contrary, he asserted that he eliminated the psychiatric problems referred to by Dr. Dost as the cause of Mr. Gauthier's cognitive impairments because the cognitive impairments appeared first and the psychiatric problems developed only later. While the psychiatric problems probably have contributed to the severity of Mr. Gauthier's cognitive impairments, they could not have caused them. Finally, Dr. Cameron strongly disagreed with Dr. Dost's assertion that "[t]he effect size of mTBI on neurocognitive function is zero."

[92] In cross-examination, both Dr. Filbey and Dr. Cameron accepted the accuracy of the following quotation from one of the articles appended by Dr. Dost:
Post-traumatic amnesia (PTA) has been related to outcomes in many … but not all ... studies involving patients with moderate to severe traumatic brain injuries. By inference, mainly, it is often presumed that PTA is also a predictor of outcome following mild traumatic brain injury. However, the duration of PTA in mild cases is difficult to determine because, by definition, it is a relatively short period of time and it is rarely assessed prospectively. The accuracy of retrospective reports of PTA is questionable.

ii. Conclusion on brain injury

[93] I have concluded that Mr. Gauthier probably did sustain a mild traumatic brain injury in the accident.

[94] I accept the opinions of Drs. Cameron, Friesen, and Filbey to that effect.

[95] Dr. Dost's rationale for disagreeing with them rests on a faulty premise. In forming his opinion to the contrary, Dr. Dost assumed that Mr. Gauthier did not suffer a loss of consciousness at the time of the accident because Mr. Gauthier is recorded as having stated as much to the ambulance attendants and to the medical personnel in the emergency ward at the hospital. Dr. Dost inferred from those attributed statements and the fact that Mr. Gauthier equated a loss of consciousness with a gap in memory during their conversation on November 9, 2017, that Mr. Gauthier did not suffer a gap in memory on June 3, 2013. From this, Dr. Dost inferred that Mr. Gauthier's currently reported gaps in memory must have developed later, and therefore for reasons unrelated to any trauma to the brain caused by the accident.

[96] There are several problems with Dr. Dost's assumptions. First, irrespective of what may have occurred between Dr. Dost and Ms. Palmer, it is clear that Mr. Gauthier initially told Dr. Dost that he thought he had lost consciousness because he had been "knocked out." Although Mr. Gauthier subsequently accepted Dr. Dost's suggestion that he believed he was knocked out on June 3, 2013 because he had gaps in his memory today, it does not follow that he had no gap in his memory on June 3, 2013. Even if one assumes that the " LOC" notations derived from something that Mr. Gauthier said on one or more occasions that evening, it is not clear what that was or what he thought it meant at the time. The circumstances were very different and so, presumably, was Mr. Gauthier's perception of what he had been experiencing and his ability to process it.

[97] I agree with Dr. Dost that the contemporaneous medical records may suggest that Mr. Gauthier was not in a state of post-traumatic amnesia for as long as "several hours" after the accident, as Dr. Cameron inferred in para. 29 of his first report. Mr. Gauthier's memory of most of that period may have been erased subsequently, as Dr. Dost inferred. But the records do not undermine Dr. Cameron's central hypothesis, expressed in the previous sentence, that Mr. Gauthier's period of amnesia, prior to a loss of consciousness or altered state of consciousness, was probably just a few seconds in duration. That sequence is strongly supported by the testimony of Ms. Waters, which I find to be reliable and consistent with the other evidence in the case, including the contemporaneous photographs of the scene and Mr. Gauthier's own limited recollection of those events. Ms. Waters testified that when she interacted with him immediately after the accident, Mr. Gauthier did not respond to questions, did not move and did not make eye contact – symptoms acknowledged by Dr. Dost in cross-examination to be indicative of post-traumatic amnesia.

[98] Moreover, Dr. Dost rests his conclusions on his assumption that Mr. Gauthier reported no loss of consciousness several minutes after the accident and later, even though a loss of consciousness is only one of several factors that could support the diagnosis of a mild traumatic brain injury. These include the following:

1. Any period of loss of consciousness;
2. Any loss of memory for events immediately before or after the accident;
3. Any alteration in mental state at the time of the accident (e.g., feeling dazed, disoriented, or confused); and
4. Focal neurological deficit(s) that may or my not be transient;

but where the severity of the injury does not exceed the following:

- Loss of consciousness of approximately 30 minutes or less;
- After 30 minutes, an initial Glascow Coma Scale (GCS) of 13-15; and
- Posttraumatic amnesia (PTA) not greater than 24 hours.

[99] I also agree with Dr. Cameron that Dr. Dost incorrectly assumed that the psychological problems, such as the pain, stress and lack of sleep that Mr. Gauthier was reporting in November 2017, dated back to the accident and therefore were more likely to be the true source of his cognitive impairments. I find that while Mr. Gauthier's pain symptoms obviously originated with the accident, they improved over time. The stress and sleepless nights, however, were associated more with Sitka's later brush with insolvency than the accident. His cognitive impairments, on the other hand, all clearly date back to the accident.

[100] Finally, I also agree with Dr. Cameron and Dr. Filbey that Dr. Dost overstated the content of the literature he appended to his report in taking from it the proposition that "[t]he effect size of mTBI on neurocognitive function is zero."

Gregg v Ralen, 2018 BCSC 171 (CanLII), <https://canlii.ca/t/hq75f

Dr. Rehan Dost

[85] Dr. Dost is a neurologist who saw the plaintiff for an independent medical examination in August 2016. He spent a very short period of time with the plaintiff: 37 minutes. His report of August 19, 2016 succinctly sets out his opinion: the plaintiff did not suffer a MTBI in the accident.

[86] Dr. Dost's conclusion is based on the history he took from the plaintiff and his examination of the clinical records. The plaintiff did not suffer a loss of consciousness, has no amnesia, and was not in a confusional state at the time of the accident. He says there is nothing in the clinical records to satisfy the inclusionary criteria for a MTBI. According to the World Health Organization ("WHO"), the possible clinical markers to support a diagnosis of a MTBI are: loss of consciousness, amnesia, disorientation or confusional state immediately post-trauma.

[87] Dr. Dost is aware that the plaintiff reported to Dr. Hay that he was “dazed” at the time of the accident. However, Dr. Dost is of the view that the fact that the plaintiff was “dazed” does not satisfy the WHO criteria for a diagnosis of a MTBI. The reason that “dazed” is no longer considered to be a clinical marker is that being dazed can mean something other than an alteration in mental state.

[88] Dr. Dost notes that the plaintiff reports a variety of cognitive symptoms, including headaches, poor sleep patterns, depressed mood, and decreased memory and focus. However, he opines that the plaintiff does not have brain damage because:
a) he did not sustain a traumatic brain injury;
b) the MRI of his brain is normal;
c) most patients with subarachnoid hemorrhage recover without permanent brain damage; and
d) his “non-brain” injury factors more than explain his presentation.

[89] Dr. Dost is “concerned” that the plaintiff’s non-brain factors include an undiagnosed sleep disorder. He believes that sleep apnea is the most likely etiology for his symptoms and that it is strongly associated with cognitive problems. Accordingly, he recommends a sleep study.

[90] Dr. Dost also notes that the literature suggests that 95% of MTBIs resolve within three months. However, he agrees that patients who develop post-concussion syndrome can have persisting cognitive symptoms. These symptoms are usually due to psychiatric factors and chronic pain rather than TBI factors.

[91] In cross-examination, Dr. Dost agreed that other definitions of the clinical markers for diagnosis of MBTI are widely used and accepted. He acknowledged that the 2013 edition of Brain Injury Medicine indicates there is “no universally accepted definition” of MBTI markers. Further, he acknowledged that the American Congress of Rehabilitation Medicine accepts a finding that a patient is “dazed” as satisfying the inclusionary criteria for a diagnosis of MTBI. He also acknowledged that medical imaging cannot be used to diagnose a MTBI; rather, it is a clinical diagnosis.

[96] Dr. Cameron also disagreed with Dr. Dost’s opinion regarding the clinical criteria for a diagnosis of MTBI. He is of the view that the finding that the plaintiff was “dazed” after the accident does satisfy the criteria. Dr. Cameron assumes that Dr. Hay (who took the history), was satisfied that the plaintiff had a sufficiently altered consciousness for the diagnosis. The words “dazed” and “confused” are used interchangeably by neurologists.

[97] In his report, Dr. Cameron highlighted other reasons for disagreeing with Dr. Dost. These include:

- Dr. Dost's statement that the plaintiff "does not have brain damage" because "he did not sustain a primary traumatic brain injury" is unhelpful and not an argument against a brain injury.
- Dr. Dost's opinion does not take account of the plaintiff's early development of cognitive issues. The clinical records document cognitive complaints within days of the accident. Dr. Dost's suggestion that the cognitive problems were caused by psychological problems that were caused by a sleep disorder does not accord with the chronology. Dr. Cameron does agree with Dr. Hay that "the psychological problems were probably subsequently contributing to or aggravating the cognitive problems which predated the onset of the depression."
- Dr. Dost's suggestion that the plaintiff's cognitive problems were caused by an undiagnosed sleep disorder is purely speculation. The plaintiff has never been diagnosed with a sleep disorder. Further, the cognitive problems experienced by the plaintiff could not have been associated with a sleep disorder because they could not have developed overnight immediately following an accident as they did. Dr. Cameron states as follows:

Also, Mr. Gregg was documented to have a disturbed sleep pattern also within a day or two of the accident, long before he developed the symptoms of depression. The problems with his sleep were caused by the injuries that he sustained at the time of this accident. He had difficulty sleeping within a couple of days of accident. This is in part due to Mr. Gregg developing symptoms of post traumatic brain injury syndrome following this accident. The majority of patients who develop symptoms of post traumatic brain injury syndrome report disrupted sleep.

- Dr. Dost concludes that the plaintiff does not have any specific disability. This ignores almost all of the clinical records that document significant disabilities following the accident.

[111] Here, the temporal connection is such that there are few other possible explanations for the array of symptoms suffered by the plaintiff. The symptoms developed immediately after the accident and it is difficult to find another event that could explain them. As I have rejected the possibility that the plaintiff misrepresented his symptoms, the only other possible cause put forward by the defendants for the cognitive and psychological symptoms suffered by the plaintiff is that his cognitive problems are caused by his psychological status that is in turn caused by an undiagnosed sleep disorder. This was the theory put forward by Dr. Dost.

[112] I cannot accept that the plaintiff's symptoms are caused by an undiagnosed sleep disorder or some non-tortious psychological disturbance. I conclude on a balance of probabilities that the plaintiff did suffer a MTBI in the accident. The defendants argue that the diagnosis of a MTBI is not supportable because of two opinions of the defendants' medical experts: Dr. Sui's opinion that the plaintiff did not suffer a subarachnoid hemorrhage in the accident; and Dr. Dost's opinion that the plaintiff did not suffer a MTBI. While I agree with Dr. Sui's opinion, that does not mean that the plaintiff did not suffer a MTBI. With regard to the diagnosis of a MTBI, I accept the evidence of Drs. Hay and Cameron.

[113] The radiologist's reading of the CT scan taken on September 24, 2011 caused the plaintiff's physicians to believe that he may have suffered a brain injury in the accident. In retrospect, this probably assisted his treatment, as the physicians were concerned about the possibility of a brain injury from the start. However, the misreading of the CT scan is not relevant to the finding I have to make. I accept the opinions of Drs. Sui and Cameron that it is likely the plaintiff did not suffer such an injury; the image was, as Dr. Sui said, an artifact. However, I also accept Dr. Cameron's opinion that the presence of a hemorrhage has little bearing on the diagnosis of MTBI because the vast majority of patients with MTBIs do not have abnormal CT or MRI scans. Drs. Sui and Cameron agreed that the diagnosis of a MTBI must be made clinically.

[114] Dr. Dost's opinion that the plaintiff did not suffer a MTBI was based on his rejection of Dr. Hay's diagnosis, and the finding that the plaintiff met the criteria for diagnosing a MTBI because he was "dazed" following the accident. Dr. Dost was not a good witness. He seemed to place no importance on the history of the plaintiff's symptoms showing that he suffered cognitive issues shortly after the accident. Dr. Dost also spent very little time with the plaintiff and little effort to explore the symptoms he suffered from following the accident. Instead, he opined, contrary to all of the plaintiff's physicians and the clinical records, that the plaintiff suffered no significant disabilities.

[115] Dr. Dost relied on the WHO criteria for diagnosis of MTBIs to reject Dr. Hay's clinical diagnosis. However, he acknowledged in cross-examination that other definitions of the criteria for diagnosis of MBTI are widely used and accepted and that there is no universally accepted definition of MBTI markers. His adamant insistence that the plaintiff did not suffer a MTBI given these admissions and the plaintiff's history of symptoms seriously weakens his opinion. He did not appear to give any credence to Dr. Hay's clinical diagnosis, even though he made little or no effort to try to understand the patient's history and clinical situation.

[116] Dr. Hay, by contrast, was a persuasive witness. He acknowledged the difficulties in diagnosis of MTBI, but was satisfied that the plaintiff's situation met the criteria. Dr. Cameron emphasized the importance of the clinical assessment. I have no hesitation in accepting that Dr. Hay was aware of the need to find that the patient had suffered an altered mental state before diagnosing a MTBI.

[117] I also accept Dr. Cameron's critique of Dr. Dost's diagnosis as set out at paragraph 97 of these reasons. The timing of the development of the plaintiff's symptoms is consistent with the diagnosis of a MTBI. Further, Dr. Dost's suggestion that the plaintiff's symptoms are primarily caused by an undiagnosed sleep disorder has no support in the clinical history. As Dr. Cameron stated, it is pure speculation.

Chaudhry v John Doe, 2017 BCSC 1895 (CanLII), <https://canlii.ca/t/hms2b

[104] Neither doctor had the benefit of information from Mr. Michaels, whose evidence I found to be highly credible and reliable. His evidence is that Mr. Chaudhry did not immediately know who he was, where he was or what happened, which are consistent with symptoms of disorientation and lack of awareness. Dr. Dost relied on the ambulance crew report which did not record Mr. Chaudhry's having confusion, loss of consciousness, amnesia or disorientation; Dr. Dost commented Mr. Chaudhry "knew who he was, where he was and when he was" (p. 5). Therefore, Dr. Dost's opinion was largely based on an erroneous assumption about the nature and degree of Mr. Chaudhry's mental awareness immediately after impact. This minimises the weight I can place on his opinion.

[105] Regardless of their disagreement about whether Mr. Chaudhry suffered a concussion, however, both neurologists agreed Mr. Chaudhry suffered from chronic headaches caused by the accident. They also agree that the chronicity of the headaches has been aggravated by Mr. Chaudhry's psychiatric conditions and insomnia.

[106] Dr. Dost opined Mr. Chaudhry's headaches had not been optimally treated, and he recommended a course of treatment (trying medication and if that fails, Botox injections). However, Dr. Dost did not provide his prognosis stating that, "determining impairment or disability from a subjective report of headache is a difficult proposition" because it "ultimately depends upon on [sic] the credibility of the individual, which is beyond the scope of my expertise to comment on" (p. 7). I note despite that observation, Dr. Dost felt qualified to discredit Mr. Chaudhry's initial report that he lost consciousness.

[107] I am surprised by Dr. Dost's reluctance to comment on prognosis. He was given documentation that he obviously believed was sufficient for him to provide a diagnosis. Given that his diagnosis also depended on his "assessment" of Mr. Chaudhry's subjective reports, it is difficult to see what impediment there was to arrive at a prognosis. By contrast, Dr. Singh concluded the headaches, as aggravated by insomnia and depression, have disabled Mr. Chaudhry and his prognosis is guarded.

Howell v Machi, 2017 BCSC 1806 (CanLII), <https://canlii.ca/t/h6m5z

[266] For example, Dr. Dost's opinion provides that:
[T]he plaintiff at present has significant cognitive issues. These cognitive issues are due to non-brain injury factors of sleep alteration, psychological duress and alteration of sleep.

[267] However, on cross-examination, Dr. Dost clarified and narrowed this aspect of his opinion. He conceded that Ms. Howell had permanent brain damage. He testified that Ms. Howell's brain injury, and specifically the damage to her frontal lobes, in conjunction with her chronic pain, depression and insomnia, was likely responsible for Ms. Howell's "neuro-behavioural executive dysfunction".

[268] He also acknowledged in his report and on cross-examination that, irrespective of the label which was placed on Ms. Howell's cognitive issues, the best determinant of her future outcome is her demonstrated functional performance. He opined that her functional performance had been devastated since the Accident and that, as a result, her long-term functional outcomes could also expect to be devastated.

[269] The format of Dr. Dost's opinion was not helpful to me. He opined that the outcomes for individuals with uncomplicated mild traumatic brain injuries are similar to those with complicated mild traumatic brain injuries. He did so by referring to a number of papers listed in an appendix to his report which he testified represented the most recent research-based evidence in that regard. That evidence was not outlined or summarized in the body of his report. Nor was there any attempt to apply that evidence to Ms. Howell's particular circumstances. This made his report difficult for me to meaningfully consider.

[270] In any event, Dr. Dost acknowledged that there will be a cohort of brain injury sufferers who fall outside of the norms. He made no attempt in his report, or in his evidence, to consider whether Ms. Howell was one of those who fell outside the norms.

[271] It was also apparent during his evidence that Dr. Dost had not reviewed Ms. Howell's post-accident medical records, including her imaged brain trauma, or the other expert medical legal opinions which had been provided to him. He did not conduct any analysis of whether the imaged damage to Ms. Howell's frontal lobes correlated to the documented cognitive and executive dysfunctions that other treatment providers and experts had recorded.

Norton v Dong, 2017 BCSC 2282 (CanLII), <https://canlii.ca/t/hp76c

[9] Consequently, he ordered the following, which counsel agreed is verbatim. This is part of the order only:
. . . any report that may result from the examination [by Dr. Dost] shall be restricted to the issue of whether Botox injections may be effective in treating the Plaintiff's headaches.
That order was made on February 8, 2017.

[10] On March 13, 2017, defence counsel wrote an instructing letter to Dr. Dost, which is four pages in length, and a copy of which is attached to the back of Dr. Dost's report. In the instructing letter, defence counsel said this in the third paragraph:
On February 8, 2017, the B.C. Supreme Court made an order compelling the Plaintiff to attend at a medical examination by you, April 6, 2017. As a term of the order, any report that may result from the examination shall be restricted to the issue of whether Botox injections may be effective in treating the Plaintiff's headaches. To explain that restriction, I set out the context below.

[11] Then for approximately a page, the usual standard form sort of context appears. To that point, all is well. However, towards the bottom of page two of the letter, the following appears, and once again, I quote:
Once you have reviewed the enclosed material and examined the Plaintiff, please provide us with your opinion as to whether further Botox injections may be effective in ameliorating the headaches from which the Plaintiff is said to be suffering, and to what extent.

[12] Then with no break except for a break between paragraphs, the next paragraph reads as follows:
Once you have examined Mr. Norton please contact me to let me know what your findings are before you write your report. If a report becomes necessary please include the following, but you need not refer specifically to the questions: . . .

[13] What follows is a bullet-point list of what looks like 11 different topics, none of which mention Botox, which include the plaintiff's history and prognosis, future activities and capacity to work, whether the complaints were caused by the motor vehicle accident. I need not go on; the letter is going to be marked together with the report on these proceedings. The list refers to numerous things which were not permitted to be in a report as a result of Master Keighley's order. It is particularly troubling because immediately before that list begins are the words, "If a report becomes necessary, please include the following", and then that list appears.

White v. Bysterveld, 2016 BCSC 1952 (CanLII), <https://canlii.ca/t/gv93s

138] In Dr. Dost's opinion, Ms. White did not sustain a mild traumatic brain injury in the accident. On his review of Dr. Tai's records he found no documentation of loss of consciousness, amnesia, disorientation or confusion at the time of the collision. While Dr. Tai did observe that Ms. White was "disoriented and confused", Dr. Dost thought those observations were inadequate to found a diagnosis of MTBI, when they could also apply to the plaintiff's stress reaction, disequilibrium from vestibular injury, and the effects of acute pain and associated sleep disruption. Further, in Dr. Dost's view, the plaintiff's actions following the accident, including exchanging information with the other driver, obtaining a rental vehicle and driving home were inconsistent with traumatic

brain injury. Dr. Dost also noted the MRI of the plaintiff's brain was normal. In Dr. Dost's view, the plaintiff's ongoing cognitive issues were attributable to her pre-existing cognitive impairment due to stroke superimposed upon the effects of chronic pain, psychological factors and sleep alteration.

[139] Dr. Dost thought the only evidence suggesting brain injury was the plaintiff's self-report of a brief period of amnesia. He thought this was an insufficient indicator of a traumatic brain injury, noting the natural attrition of memories over time, that gaps in memory are to be expected, and that a few seconds of amnesia may occur during a psychologically traumatic event in the absence of a traumatic brain injury.

[140] Dr. Dost thought that even if the plaintiff had sustained an MTBI in the accident she had made a full recovery and had no brain damage. Even in this scenario, which he regarded as unlikely, her ongoing cognitive problem reflected her pre-existing condition superimposed upon her untreated chronic head pain, psychological factors and untreated sleep disorder.

[163] I find that Ms. White suffered a mild traumatic brain injury in the motor vehicle accident. That finding is supported by the opinions of Drs. Cameron, Kaushansky, Anderson and Miller. I prefer their evidence to the opinion of Dr. Dost, who, in cross-examination, acknowledged errors in his discussion of both the clinical reporting of Ms. White's post-concussive symptoms and the duration of her post-traumatic amnesia.

Chappell v. Loyie, 2016 BCSC 1722 (CanLII), <https://canlii.ca/t/gtrd8

[86] Both neurologists who testified were clearly knowledgeable and both were firm in their opinions, but Dr. Dost also appeared to rely too heavily on the medical records. In my view, this caused him (as well as Drs. Leith and Waseem) to parse too much detail from notes prepared by others, without considering the human element of the patient.

Wohlleben v. Dernisky, 2016 BCSC 976 (CanLII), <https://canlii.ca/t/grwhb

[2] The narrow issue on this application is whether the plaintiff's subjective concerns about Dr. Dost based on her review of case law provided to her by her counsel are sufficient to dismiss the application.

[3] The plaintiff's affidavit at paragraphs 8 through 14 sets out her position concerning Dr. Dost:

8. Upon my request, my counsel has provided me with copies of the decisions in recent cases in which Dr. Dost has acted as an expert. In the following paragraphs, I give a few examples of the passages that deal with Dr. Dost's expert evidence.

9. In her decision in *Gabor v. Boilard*, 2015 BCSC 1724, Madam Justice Ballance of this Honourable Court identified "many shortcomings of Dr. Dost's opinion"' including, but not limited to, the following:
(a) On two different occasions, Dr. Dost made errors in recording the plaintiff's report to him about the accident. On another occasion, Dr. Dost recorded something that the plaintiff testified she did not believe she had told Dr. Dost (paragraph 438);
(b) Dr. Dost's report "strangely" failed to make reference to an entry in the plaintiff's family physician's notes which contained a diagnosis of concussion (paragraph 439);
(c) Dr. Dost emphasized that the post-accident gap in the Plaintiff's memory was "extremely brief"; however, this Honourable Court noted that "the preponderance of the evidence" did not establish that (paragraph 440); and
(d) Dr. Dost placed reliance on how "litigation effect" contributed to the development of the plaintiff's cognitive deficits; however, in cross-examination he acknowledged that he had not canvassed the topic with the plaintiff (paragraphs 449 and 450).
10. In his decision in *Reimer v. Bischoff*, 2015 BCSC 1876, Mr. Justice Cole of this Honourable Court noted at paragraph 42 that, "Dr. Dost was combative and tended to be more of an advocate than an independent expert".
11. In his decision in *Hsu v. Choquette*, 2015 BCSC 1123, Mr. Justice Schultes of this Honourable Court noted at paragraph 72 that, "both Dr. Dost's reports and his testimony were more combative, and seemed strategically directed to defeating the availability of this disputed form of TOS [thoracic outlet syndrome]. The portion of his evidence that actually dealt with Ms. Hsu was rather superficial by contrast".
12. On account of the foregoing, as well as other decisions, unfortunately, I find myself unable to repose my trust and confidence in Dr. Dost, and offer him the level of cooperation necessary for the examination to reach a meaningful conclusion.
13. I further note that in the second paragraph of page 2 of Dr. Mackoff's medical legal report, he writes:
"There are two factors that complicate fully understanding the severity of her psychological and physical difficulties. First, … Cst. Wohlleben is typical of elite athletes. She believes pain and physical limitations are artifacts of "not trying hard enough" and therefore should not be acknowledged or if acknowledged should be minimized".
And in the next paragraph he adds:
"Second, Cst. Wohlleben works as a police office. Common amongst many police officers, Cst. Wohlleben is excessively stoic and clearly minimizes her physical and psychological distress".
14. On account of these findings, I believe my ability, or lack thereof, to repose trust and confidence in Dr. Dost assumes greater significance.

[4] The extracts from the cases cited in the plaintiff's affidavit simply demonstrate that, in some trials, the trial judge has preferred the evidence of other experts to that of Dr. Dost.

[5] In the present application, it is clear from the plaintiff's affidavit that the impetus behind the opposition to Dr. Dost comes from her counsel, and not from the

plaintiff herself. It is highly unlikely, in my view, that plaintiff's counsel provided the plaintiff with copies of decisions in which Dr. Dost was a witness at the plaintiff's request. The selection of cases does not include the cases referred to before me by counsel for the defendants in which Dr. Dost's evidence was accepted.

[6] Counsel for the defendants referred to other trial judgments in which the trial judge accepted Dr. Dost's opinion. For instance, in one case, the trial judge found him to be "clear, forthright, and helpful."

[7] There is no demonstrated misconduct on the part of Dr. Dost, and indeed, the plaintiff does not suggest there is any. The plaintiff says that she finds herself unable to repose her trust and confidence in Dr. Dost and offer him the level of cooperation necessary for the examination to reach a meaningful conclusion. This evidence is simply a bare assertion and not based on any evidence of misconduct.

[8] As for the relevance of Dr. Mackoff's statement in his report that the plaintiff is being "excessively stoic and clearly minimizes her physical and psychological distress", this description of her personality forms no reasonable foundation for the plaintiff's subjective view that she is unable to repose trust and confidence in Dr. Dost.

Gabor v. Boilard, 2015 BCSC 1724 (CanLII), <https://canlii.ca/t/gl9m1

[438] Dr. Dost agreed that he had made two errors in his summary of Ms. Gabor's report to him about the Accident. One mistake on this key matter was that he recorded that she said she saw a flash of light. Secondly, he noted that she reported she had been taken to the hospital where she had a very cursory examination. Both pieces of information are incorrect. Dr. Dost also recorded that Ms. Gabor told him she recalled the impact of the collision. Ms. Gabor testified that she did not believe she had told him she recalled the actual impact because she does not recall it, although she may have a memory of the sound of it.

[440] The defendants emphasize, as had Dr. Dost, that any gap in memory experienced by Ms. Gabor would have been extremely brief. However, the preponderance of the evidence, including Mr. Boilard's testimony, does not establish that Ms. Gabor was assisted from her car within mere seconds of the collision such that the gap in her memory was fleeting. Even if the gap had been extremely brief, as it was characterized by Dr. Dost, none of the medical experts opined that a short duration of amnesia militated against the likelihood that the individual had sustained a mild traumatic brain injury, or otherwise did not satisfy the accepted diagnostic criteria.

[441] One of the reasons given by Dr. Dost in support of his view that Ms. Gabor's gap in memory should not be interpreted as reflecting a mild traumatic brain injury was the natural attrition of memories over time. However, in her retelling of the Accident

from the outset, I find that Ms. Gabor credibly and consistently reported that gap in her memory. She has never been able to fill in that blank. That fact discredits Dr. Dost's reasoning that the gap is partially explainable by the gradual wearing away of her memory with the passage of time.

[442] Dr. Dost did not challenge the legitimacy of the diagnostic elements of mild traumatic brain injury endorsed by the ACRM, which permits self-reporting of the criteria. However, he testified that one has to be cautious and circumspect in applying any self-reported factors. His view accords with common sense.

[443] Dr. Dost agreed that neuropsychological testing of the kind conducted by Dr. Bogod provides excellent discriminant validity in identifying cognitive deficits and abnormalities and their effect on a person's level of function. He does not take issue with the results of Dr. Bogod's testing of Ms. Gabor. He emphasized that what Dr. Bogod's testing cannot reveal is the diagnosis or the reason for the presence of the measured deficits.

[444] As to etiology, Dr. Dost stressed that non-brain injury factors have been found to play a significant role in the pathogenesis of post-concussion syndrome. Given that, he considers it vital that the assessor search for clinical co-founders, which he believes typically offer far more persuasive and treatable explanations for the cognitive complaints. Those co-founders would include the well-documented cognitive inefficiencies strongly associated with sleep disruption, psychological duress and/or poorly controlled pain. Dr. Dost clarified that, in Ms. Gabor's case, "psychological duress" referred to the convergence of her mild psychiatric symptoms (i.e. her depressed mood and anxiety issues), which he conceded may not satisfy the clinical threshold to support a formal diagnosis, plus the effects of two other factors: the litigation effect and iatrogenesis, also known as the diagnostic threat.

[445] I found troubling the lack of depth in Dr. Dost's analysis as to the degree that Ms. Gabor's mild, and possibly subclinical, psychological symptoms contributed to the psychological duress that he opined is responsible for her cognitive deficits. Of similar concern was that Dr. Dost did not satisfactorily explain how it was that such cognitive deficits have persisted in the face of Ms. Gabor's much improved psychological condition and pain. As a further side note, I question whether this differential diagnosis might fall outside of Dr. Dost's expertise as a neurologist in any event.

[446] Dr. Dost testified that the diagnostic threat is a condition created by the process of medicine itself. Expressed in simple terms, if a doctor, who is an authoritative figure, tells the patient she is brain damaged, then she will behave as though she has brain damage and that will have a significant impact on her neurological function. In other words, a misdiagnosis of mild traumatic brain injury can result in a patient, who does not have such an injury, displaying cognitive symptoms that are consistent with it.

[447] Dr. Dost's evidence concerning the presence and application of the diagnostic threat was also deficient on specifics. He did not adequately identify the precise diagnosis or diagnoses that he says triggered the diagnostic threat in Ms. Gabor's case. I am left wondering whether he was referring to Dr. Tan's warning on July 4, 2011 to keep a lookout for the signs and symptoms of a concussion, or to her actual diagnosis of concussion made one week later (even though he does not refer to that diagnosis in his report), or whether he was referring to a diagnosis subsequently given to Ms. Gabor at the G.F. Strong Rehabilitation Centre or by one of the other medical experts who assessed her. The failure to pinpoint the diagnosis or diagnoses said to be at the core of the diagnostic threat seriously undermined the force of Dr. Dost's opinion as to the influence of that factor upon Ms. Gabor's persistent cognitive impairments. As well, there was no cogent evidence as to whether or how the effects of iatrogenesis (which, if it did apply in Ms. Gabor's case, was itself clearly caused by the Accident), might ever dissipate or resolve.

[448] Also concerning is that, in his report, Dr. Dost described it as "highly unusual" that Ms. Gabor had not been taken to hospital and relied on that fact in concluding that she had not sustained a brain injury. Yet, at trial he readily conceded that an individual could sustain a mild traumatic brain injury and not go to the hospital.

[449] Another problem is the reliance Dr. Dost placed on the inadequately explained notion of how the "litigation effect" played a contributory role in the development of Ms. Gabor's cognitive deficits. Ms. Gabor acknowledged that being involved in this case was not "a walk in the park" and mentioned, in particular, that her examination for discovery and attending at the various defence medical appointments had been stressful. However, her testimony, buttressed by the evidence of her parents and Ms. Olson, established that by and large she had elected to take a disinterest in the litigation process. Ms. Gabor effectively delegated that role to her parents until increasing demands were made upon her as things intensified closer to the trial date.

[450] During his cross-examination Dr. Dost appeared to distance himself from the importance of this factor. He explained that he had not canvassed the topic with Ms. Gabor to assess its effect upon her, and conceded that it was only a possible contributory factor which he had considered relevant essentially because some of the literature indicated it could be. Simply presuming that it applied as a causative factor in Ms. Gabor's case served to undercut the potency of Dr. Dost's opinion and detracted from his sway as an expert. I would add that Dr. Dost did not sufficiently identify the circumstances in which it was anticipated that the impact of the stress from this litigation would no longer influence Ms. Gabor's cognitive function (e.g. once the trial ended, or when Reasons for Judgment were issued, or following an appeal, or at some other turning point).

[451] In one of the appendices to his report, Dr. Dost provided commentary on the natural history of singular instances of mild traumatic brain injury and the small proportion of that population, between five and fifteen percent, who fall outside of the

usual expectations for complete recovery and go on to experience post-concussion syndrome. At trial, he explained that in preparing that appendix, he had put aside his opinion that Ms. Gabor did not incur a mild traumatic brain injury, and for the purpose of his analysis only, assumed that she had indeed sustained such an injury. It was within that highly qualified context that Dr. Dost discussed the medical controversy surrounding the concept of post-concussion syndrome, emphasizing among other things that non-brain injury factors are at play in causing symptoms consistent with post-concussion syndrome. The majority of his remarks were stated in general terms with citations to the references he relied on for them, and were not said to be specific or necessarily applicable to Ms. Gabor. Many of the propositions he espoused had also been mentioned by Drs. Smith, Bogod and Caillier in their respective reports and are not contentious.

[452] When explaining the relationship of the appendix to his main report and the alternative discussion it was intended to raise, Dr. Dost agreed that, in the absence of MRI imaging showing otherwise, Ms. Gabor fell within the class of uncomplicated mild traumatic brain injury cases. Ms. Gabor's counsel construed Dr. Dost's statement as being a concession or a new opinion to the effect that Ms. Gabor had indeed suffered a mild traumatic brain injury from the Accident. However, it was abundantly clear that in giving his testimony Dr. Dost was not expressing that opinion or in any way retreating from his primary opinion that Ms. Gabor did not suffer a mild traumatic brain injury in the Accident.

[453] In Dr. Dost's opinion, Ms. Gabor's headaches were consistent with chronic headaches associated with whiplash and they did not result in any neurological impairment or disability. The most he could say about her cervical mid-back pain and bilateral hip pain was that they were not neurological in origin. Ms. Gabor is not asserting that they are.

[454] Dr. Dost concluded that from a neurological perspective, Ms. Gabor was not impaired or disabled, did not require any rehabilitation program therapy or other treatment, and was not restricted in terms of her employment or impaired for future employment. It is crucial to appreciate that his opinion is specifically couched in terms of, and is confined to, a neurological point of view.

[455] The cumulative effect of the many shortcomings of Dr. Dost's opinion is such that I prefer the opinions of Ms. Gabor's medical experts on every point of disagreement.

[466] Dr. Riar admitted that he had not asked Ms. Gabor whether she found this litigation to be a stressful matter and did not examine any extrinsic evidence to assess its potential impact. Much like Dr. Dost, he presumed that the litigation was a stressor to her because he presumed, based on his reading of medical literature, that litigation causes stress to any person involved in it. From that, he made the reasoning leap that the litigation stress experienced by Ms. Gabor was of sufficient intensity to play a

contributory role in her cognitive failings. That was essentially the full extent of Dr. Riar's analysis on that point.

[467] Dr. Riar admitted that it was very difficult to know whether the diagnostic threat was at play in this or in any particular case. He agreed that he had not really probed that potential connection in the case at hand. And yet, he had identified it as a causative factor.

[468] My criticisms of Dr. Dost's shallow analysis of the litigation effect and the diagnostic threat as they pertain to Ms. Gabor apply equally to Dr. Riar's analysis.

Hermanson v. Durkee, 2014 BCSC 877 (CanLII), <https://canlii.ca/t/g6x8m

[153] The things the plaintiff can do must be placed in context. For example, the fact that the plaintiff has succeeded in obtaining some employment is a positive, but none of those jobs have lasted and all employers noted the deficits. The plaintiff has not hurt himself when left alone, but he is not living independently and has not managed his instrumental activities of daily living. The extrapolation the defence urges is not supported by the evidence. Another example is driving where, again, the defence and Dr. Dost say supports conclusions about living independently that I simply do not accept.

P. B. v. State Farm Mutual Automobile Insurance Company, 2013 ONFSCDRS 139 (CanLII), <https://canlii.ca/t/jq8fg

Throughout this decision, I will refer to the insurer's experts where their reports inform my decision. The insurer conducted two catastrophic impairment assessments. The first occurred in November 2007 and the second in March and April 2011. Dr. Benjamin Clark, physiatrist, completed the executive summary for the first assessment. Assessments and reports were completed Dr. Rehan Dost, neurologist, Dr. Richard Kaminker, orthopaedic surgeon, Dr. Donald Young, psychologist and Mr. Michael Drinkwater, registered physiotherapist. For the second assessment Dr. Ben Meikle, physiatrist, completed the catastrophic rating with assessments and reports being completed by Dr. Clark, neurologist, Dr. Ken Scapinello, psychologist, and Ms. Karen Dmytryshyn, occupational therapist.

[]
Dr. Dost only wrote that the temporal lag between the accident and the disc herniations was incompatible with causation without further explanation. Despite his opinion on causation, in the "specific questions" portion of his report, Dr. Dost states the following to the question,

Q: What is the etiology of the diagnosed injury or condition?

A: Dr. Stewart concluded that there was a reasonable probability that she had a lumbar spine injury in the accident that caused some disc herniation.

Given his reference to and reliance on Dr. Stewart's opinion, Dr. Dost confuses his conclusion on causation and did not testify to explain.

M.G. v. The Economical Mutual Insurance Company, 2012 ONFSCDRS 153 (CanLII), <https://canlii.ca/t/jq8ch

As can be seen from the chart above, the only assessment of physical impairments that falls short in this case is that of the Custom Rehab team. I did not find their assessment and rating to be as reasonable or as persuasive as those of Dr. Garner or the Drs. Becker for a number of reasons. The first reason is that I do not find the Custom Rehab team had a realistic or accurate grasp of Ms. M.G.'s actual functional abilities for her activities of daily living. As discussed above, I did not find Ms. Krushed's extrapolations from her observations of Ms. M.G.'s abilities to complete daily living tasks and engage in social activities to be realistic or reasonable. Consequently, to the extent Dr. Mathoo and Dr. Dost relied on Ms. Krushed's faulty statements and conclusions, their reports are similarly inadequate.

The second reason I prefer the evidence of Kaplan and Kaplan and Omega over that of Custom Rehab, is that I find the Custom Rehab team's approach resulted in their under-rating of Ms. M.G.'s physical impairments. There appear to be a number of reasons for this. One is that the team members did not consult with each other, or even exchange their reports; each simply conducted his or her own assessment and prepared a report, and the team leader, Dr. Mathoo, included their findings in his Executive Summary. I find this lack of communication impeded the exercise of clinical judgment or interpretive analysis by team members - essential components of assessing the impact of impairments on daily functioning.

The effect of this compartmentalized approach can be seen in how the Custom Rehab team members accounted, or rather, failed to account, for the effects of pain on daily functioning...

Similar difficulties arose regarding Custom Rehab's view that Ms. M.G.'s complaints of incontinence were not rateable. As noted, I find the evidence indicates she complained consistently after the accident of this condition, which did not exist before, and, on a balance of probabilities, these symptoms were caused by the accident. Dr. Mathoo and Dr. Dost acknowledged Ms. M.G.'s complaints but dismissed them....

Alyse Mallat v. Personal Insurance Company of Canada, 2011 ONFSCDRS 115 (CanLII), <https://canlii.ca/t/jq82x

On December 3, 2007, Ms. Mallat applied to Personal for a determination of catastrophic impairment. Personal denied her application for a catastrophic designation on the basis of the reports of their expert, Dr. Dost, on April 22, 2008 and June 10, 2008, wherein he opined that the Glasgow Coma Scale ("GCS") scores were recorded after sedation and intubation and therefore were invalid. Ms. Mallat disagreed with this finding and applied for mediation.

5. Personal declined the request for catastrophic impairment status and arranged for a paper review to take place with MDAC. The prime reviewer was Dr. Rehan Dost, neurologist.

For these reasons, I give little, if any, weight to the opinion of Personal's expert, Dr. Dost that intubation and medications administered for the purposes of surgery invalidated Ms. Mallat's GCS score of 8. I find that Dr. Dost ignored very relevant medical information that he should have taken into consideration when giving his opinion.

I find that based on the hospital records, which Dr. Dost should have reviewed, his assumption that Ms. Mallat was intubated at the time the GCS was administered was clearly wrong.

Dr. Dost missed the very relevant fact that when the surgery was finished at 12:33 a.m., the hospital records show that Ms. Mallat, who was only intubated for the surgery, was no longer intubated post-surgery. Nevertheless, in his very brief report he states that the "sub score" of 8 (taken 3½ hours post-surgery) was invalid because Ms. Mallat was intubated at the time the GCS was administered.

Dr. Dost in his report stated: "The GSC [sic] scores of 8 were recorded post-surgery ***after*** the client had been given large doses of medications, which would significantly alter the GCS score, and indeed induce anaesthesia for the necessary surgical procedures. Consequently, the depression in the GCS score is not due to traumatic brain impairment, rather due to the effects of medication. [Emphasis added]

Again, I find that this is an inaccurate reflection of the medical evidence.

The hospital records show that from the time of her accident until her surgery, Ms. Mallat had been administered the powerful drugs, Fentanyl nine times and Propofol three times. Prior to surgery, for emergency procedures, the last time she was administered Propofol was at 5:20 p.m., and the last time she was given Fentanyl was

at 8:30 p.m. At 8:50 p.m. she was taken to the operating room, intubated and administered a general anaesthetic.

Dr. Dost, in giving his expert opinion on the effects of medication on the GCS tests, should have been aware that the drug Fentanyl when administered intravenously leaves the system within a half hour to one hour; and when administered inter-muscular between one and two hours. The drug Propofol leaves the system at a faster rate. The evidence shows that "recovery from anaesthesia or sedation is rapid. …the majority of patients are generally awake, responsive to verbal commands and oriented in approximately 7 to 8 min. [sic] [See note 7 below]"

Based on these facts, the medications opined by Dr. Dost, to "induce anaesthesia for the necessary surgical procedures" would clearly have left Ms. Mallat's system by the time she was given the GCS test three and a half hours post-surgery. Moreover, there is no medical evidence, whatsoever, that post-surgery Ms. Mallat was "administered large doses of medications" that would "induce anaesthesia."

Accordingly, for these reasons, I give little weight to Dr. Dost's opinion that a lower GCS score of 8 was a result of the effect of intubation and medications administered for the purposes of surgery.

Decision No. 824/09I, 2011 ONWSIAT 2174 (CanLII) — 2011-09-16
Ontario Workplace Safety and Insurance Appeals Tribunal — Ontario

[25] The employer retained the services of Riverfront Medical Services to prepare a multi-disciplinary report on causation. The multi-discliplinary panel was composed of the following medical professionals:

Dr. Rehan Dost, Neurologist

Dr. Dost notes that no physical examination findings have been identified by every neurologist, neuro-ophthalmologist, ENT evaluation and physiatrist with the exception of Dr. David J. Spence who found neurological findings which did not fit a known pattern of neurological injury. MRI both prior to and subsequent to the date of loss demonstrated small white matter lesions, which do not correspond to the vertebrobasilar system and are a normal finding in individuals of the employee’s age group. An MRA did demonstrate a slightly narrowed vertebral artery which is an entirely nonspecific finding and cannot be used to make the diagnosis of dissection. Dr. Dost notes that the temporal lag between the onset of vertiginous symptoms and the head impact is incompatible with traumatic injury to the central nervous system or peripheral vestibular system.

Dr. Dost puts forth that the employee sustained a “mild” closed head injury and that her current cognitive complaints are not attributable to the effects of closed head injury for the reasons detailed in his report.

Dr. Dost concludes that from a neurological perspective there is no cognitive or physical neurological impairment and hence no disability.

[45] Having so noted, the Panel also observes that neither Dr. Levy nor Dr. Dost provide an explanation as to why the worker’s symptoms are much greater since the accident compared with the period prior to the accident. Dr. Steinberg addresses this point, ascribing the worsening of symptoms to coincidence.

[46] The Panel notes that even if the view of the members of the Riverfront Medical Services multidisciplinary panel is correct, that is to say that the worker had an undiagnosed VBI condition pre-accident, that fact would not disentitle the worker. In the Panel’s view, if it were to accept that opinion, it would still be more likely than not that the worker’s pre-existing VBI condition was significantly aggravated by the workplace accident either directly on the date of the accident, or indirectly by way of the chiropractic treatment.

[47] Based on the above, it is the Panel’s conclusion that it is more likely than not that the workplace accident of February 14, 2002 caused the worker’s VBI condition. The worker is entitled to benefits for her VBI condition. This entitlement replaces the entitlement granted for the condition which had been misdiagnosed as a vestibular disorder.

M.R. v. Gore Mutual Insurance Company, 2010 ONFSCDRS 151 (CanLII), <https://canlii.ca/t/jq7tm

After the "CAT" rebuttal assessment of Kaplan and Kaplan was prepared, a copy was provided to Riverfront for comment. There is no evidence before me that Riverfront ever requested or received any additional documentation concerning the Applicant. Dr. Dost and Dr. Shapiro each prepared a response in support of their original conclusions.

Dr. Dost disagrees with the conclusions of Kaplan and Kaplan concerning the extent of the Applicant's functional limitations due to mental and behavioural impairments. Dr. Dost, in his response dated June 4, 2009, focuses on the Applicant's ability to drive. Dr. Dost suggests that the ability to safely operate a motor vehicle, the "most demanding of the ADL":

> … implies a level of attention, processing speed, memory, forethought, judgement, visuospatial organization, eye hand coordination and perceptual

integration which would preclude a rating of Marked under ADL and Concentration Persistence and Pace.

Dr. Dost states that a Marked (Class 4) rating implies that the impairment significantly impedes function, meaning all function. Thus, if a complex function (like driving) is spared, the implication is that the level of impairment cannot exceed Mild (Class 2), at least for: (1) activities of daily living; and (2) concentration, persistence and pace.

Dr. Dost also states that if any assessor or treating practitioner honestly believed that the Applicant's mental and behavioural impairments could affect his ability to safely operate a vehicle, this must be reported to the Registrar of Motor Vehicles. Subsequently, the Applicant's licence was, in fact, suspended pending the Ministry being provided with further information concerning the Applicant's psychological and cognitive condition and concerning his medications.

With respect to Social Functioning, Dr. Dost indicates that since the Applicant was able to establish some rapport with members of Riverfront's assessment team, the degree of impairment could not be Marked.

With respect to Adaptation, again Dr. Dost concludes that the ability to drive together with the ability to tolerate several medicolegal evaluations indicates a level of function which would preclude a Marked (Class 4) impairment. Dr. Dost does not explain in his report what he means when he says that the Applicant "tolerated" the evaluations and, of course, since he never bothered to seek further medical information, he would have no idea as to what effect (if any) the "CAT" assessments might have had on the Applicant once the assessments were completed.

Dr. Dost did not testify at this hearing. There is no indication that the other members of the assessment team at Riverfront concur in his opinion. I find Dr. Dost's reliance upon the Applicant's continued ability to drive in placing him in the "mild" category for three of the four areas of function to be an unreasonable method of assessing the degree of functional limitation experienced by the Applicant. According to Dr. Levitt, whose testimony I accept, driving is an "overlearned" activity — an experienced driver does not typically need to devote much conscious thought to this activity — and this is probably even more accurate for a professional driver like the Applicant. The idea that being able to drive would automatically mean that a person would be placed in the mild impairment category for three of four functional areas seems far too simplistic an approach and not one that is mandated by the *Guides*. According to the *Guides*, a person with *moderate* impairment levels can still have some useful functioning in all four areas of function. A person with *marked* impairment levels will find useful functioning significantly impeded (but not precluded). Therefore, even at the*marked* level of impairment, one can expect some useful function in multiple areas of functioning.

.....While it is not entirely the fault of Dr. Shapiro (since the Insurer failed to provide him with relevant documents that were clearly in its possession and since the Applicant in his interview tended to downplay his functional limitations), given all of the foregoing (including the admissions of Dr. Shapiro on cross-examination), I find that I cannot give the opinion of Dr. Shapiro (as expressed in his written reports) much weight. Since Dr. Shapiro was the only expert in the original report to deal with clause 2(1.2)(g) of the *Schedule*, this means that I am giving that report little weight in this case. I have also rejected the attempts by Dr.Dost to bolster Dr. Shapiro's original opinion (for reasons previously given).

Maria Augello v. Economical Mutual Insurance Company, 2008 ONFSCDRS 198 (CanLII), <https://canlii.ca/t/jq7ns

One of Dr. Brigham's claims to fame is that he participated in the development of the original guidelines, and claims to have a special insight into what was intended by the committee which draughted the original guidelines. Dr. Ameis and Dr. Brigham have posited that the intention or original meaning of the provision was that no numeric rating could be given to psychological disorders, with the result that such disorders could not directly be added to the numerical physical rating to push the whole person impairment over the necessary threshold for catastrophic impairment.

It is clear from the Catastrophic report of the Custom Rehab team, headed by Dr. Rehan Dost, neurologist, that the Insurer's experts were firmly in the Brigham/Ameis camp, finding a 20% whole person impairment, when, as they acknowledged in their own report, the amount under a *Desbiens* approach would have been 55%.

Indeed, Economical has acknowledged that should the *Desbiens* approach be found to be appropriate, Ms. Augello would meet the criteria for catastrophic impairment.