NEWFOUNDLAND AND LABRADOR
BOARD OF COMMISSIONERS OF PUBLIC UTILITIES
120 Torbay Road, P.O. Box 21040, St. John's, Newfoundland and Labrador, Canada, A1A 5B2

Hearing Transcript

2017 Automobile Insurance Review

September 7, 2018

PRESENT:

The Board:
Darlene Whalen, Chair and CEO
Dwanda Newman, Vice-Chair
James Oxford, Commissioner

Board Counsel/ Staff:
Jacqueline Glynn, Board Counsel
Ryan Oake, Regulatory Analyst
Peter O'Flaherty, Q.C., Hearing Counsel

Parties (Alphabetical Order)

Atlantic Provinces Trial Lawyers Association
Ernest Gittens

Campaign to Protect Accident Victims
Colin Feltham
Jerome Kennedy, Q.C.

Consumer Advocate
Dennis Browne, Q.C.
Andrew Wadden

Insurance Bureau of Canada (IBC)
Amanda Dean
Kevin Stamp, Q.C.
Trevor Foster

Spinal Cord Injury NL
Thomas Fraize, Q.C.
Lara Fraize-Burry

Presenters:
Dr. Karl Misik,
Presenting for the Campaign

(9:00 a.m.)
CHAIR:
Q. Good morning, everybody. I'm just going to move over to your presenter, so I'll just turn it right over to the Campaign.
MR. FELTHAM:
Q. Thank you, Chair and Commissioners. This morning we have Dr. Karl Misik. Good morning, Dr. Misik.
DR. MISIK:
A. Good morning.
MR. FELTHAM:
Q. And Dr. Misik, thank you for coming. I'd like to begin by just reviewing, I guess, somewhat briefly, your – I won't say qualifications, but your history, professional history, and then we'll move into some other stuff from there. So when did you receive your medical degree?
DR. MISIK:
A. In 1970, Dalhousie University.
MR. FELTHAM:
Q. And you've been in medical practice since that time?
DR. MISIK:

A. I have.
MR. FELTHAM:
Q. And what type of practice?
DR. MISIK:
A. It is primarily a family practice. I have done research in clinical medicine for 20 years during that period of time, and I'm also Medical Director for Canadian Blood Services, a Canadian blood agency, and I represent one of the physicians for Eastern Canada.
MR. FELTHAM:
Q. And you've been in general medical practice for – so that would be 48 years?
DR. MISIK:
A. Yes.
MR. FELTHAM:
Q. And has that been entirely in Newfoundland and Labrador.
DR. MISIK:
A. Absolutely, yes.
MR. FELTHAM:
Q. And looking at your CV, there was a mention from 1970 to present, also courtesy staff at St. Clare's Mercy Hospital?

DR. MISIK:
A. Yes, I've been courtesy staff at all the hospitals in St. John's. Courtesy basically means that I don't practice at the hospital, but I have privileges in all departments and so on.
MR. FELTHAM:
Q. And you were a member of the Board and the Executive of the Newfoundland and Labrador Medical Association from '77 to '99?
DR. MISIK:
A. Correct, and I was President in '97 and '98 of the Newfoundland and Labrador Medical Association, and then I spent several years on the Board of Directors of the Canadian Medical Association.
MR. FELTHAM:
Q. And what was the nature of those roles?
DR. MISIK:
A. They're mostly dealing with political issues that arose from various parts of the province, and afterwards it was dealing with political issues on a national scale.
MR. FELTHAM:
Q. relating to physicians?

DR. MISIK:
A. Yeah, medical politics, correct.
MR. FELTHAM:
Q. And your CV indicates you were Chair of the Council on Health Policy/Economics in the province?
DR. MISIK:
A. Correct.
MR. FELTHAM:
Q. Tell us about that?
DR. MISIK:
A. Well, I was Chair of that particular department and that mostly dealt with negotiations, negotiations with government in terms of fees and various ways that we could enhance and make the practice of medicine more efficient in this province.
MR. FELTHAM:
Q. And I also noted you were Chair of a Working Group on Primary Care Costs Effectiveness, and that was in '94, '95. Can you tell us what that was about?
DR. MISIK:
A. Yes, I was Chair of that particular committee that was struck by the Canadian

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Medical Association, because there was a certain approach by all kinds of practitioners who considered them primary care individuals, and we did a very detailed study that basically showed that, in particular, general practitioners, family physicians, and so on, are still the key to the practice of medicine in this country rather than going as a primary care person to somebody that has a different kind of take on aspects of medicine.

MR. FELTHAM:

Q. And you mentioned this before, but the CV you provided to the Board lists a number of clinical trials that you've been involved in, and you said you were doing that for about 20 years?

DR. MISIK:

A. Correct.

MR. FELTHAM:

Q. And so getting back to family medicine, you mentioned that you have operated for 48 years in the family medicine practice, and where is that located?

DR. MISIK:

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A. That is currently located, and has always been located on Topsail Road and it's aptly called Topsail Road Medical Clinic, and I'm the principal physician in a group of four at that particular facility.

MR. FELTHAM:

Q. Tell me a little more about the clinic, you know, how many patients are being seen there and what kinds of patients are being seen?

DR. MISIK:

A. We see everything from the top of your scalp to the bottom of your feet, and that includes every aspect of medicine that you can think of, and if obviously there are more substantial or serious issues that can't be dealt with in the confines of our practice, we do obviously refer to specialists and so on in our city.

MR. FELTHAM:

Q. And included in those patients, have you treated patients over the years with musculoskeletal issues?

DR. MISIK:

A. I have very many, to be quite frank, I have, and I think that is one of the reasons why

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I'm here because in the course of practicing medicine, and I still have an open clinic, in other words my patients – I don't have a cut off at this point. I've never liked that idea, so I always take in anybody when they have issues or problems, and in the course of that I do see quite a number of injured individuals through motor vehicle accidents.

MR. FELTHAM:

Q. Could you hazard a guess at the numbers over the years that you may have seen in that respect, or as a percentage of practice, whatever works for you?

DR. MISIK:

A. Right. Well, you know, I would say that every month there would be two, three, or four individuals seeking help in terms of injuries and so on, and it clearly happens more often in the winter months than it does in the summer, but we also see issues in the summer because people are a little bit more crazy in their driving habits during the summer than they would be in the winter.

MR. FELTHAM:

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Q. So of those patients that you're speaking of, I'm thinking of those who were injured in motor vehicle accidents, what are the majority of the types of injuries that those folks have suffered?

DR. MISIK:

A. The majority of the injuries are really what I call, and from a medical standpoint, they're really hyperextension injuries, and I really don't like the term "whiplash", which clearly it is commonly known by, but really from a medical standpoint they're all hyperextension injuries with often significant soft tissue components.

MR. FELTHAM:

Q. And what is a hyperextension, what do you mean by that?

DR. MISIK:

A. Well, it's the – most of the time these are rear end collisions, and by that I mean that there is a deceleration and acceleration kind of process that occurs and it causes this hyperextension of the neck. Despite the fact that most individuals tell me that they have their seat rest and their headrest

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adjusted properly, that still occurs quite frequently and that's the main area of practice in these injuries that we deal with all the time.

MR. FELTHAM:

Q. And in terms of the physical injury arising from that, what parts of the body are impacted typically?

DR. MISIK:

A. Mostly neck, upper back, shoulders, and oftentimes it does affect the lumbar area as well, meaning in the lower back area, but it does mostly stop mid back. Most of the injuries are from mid back upwards.

MR. FELTHAM:

Q. And so the summary document that you provided to the Board, you included in it some minor injury definition, things that were taken from different provinces, some examples of definitions, I would say, of minor injuries from those provinces. So I wanted to put a scenario to you to consider this for a moment. A mother who sustains a back and soft tissue injury in a rear end motor vehicle accident, do you have patients

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like this or have had patients like this over the years?

DR. MISIK:

A. Absolutely.

MR. FELTHAM:

Q. And perhaps she's unable to lift her small child or young baby, unable to walk a dog, can't sleep due to pain and discomfort, develops anxiety and depressive disorders or symptoms, can't participate in recreational, maybe they're in a softball league or some other sports, these types of things. Have you seen in your practice in the last 48 years patients who've struggled in that way as a result of soft tissue injuries from motor vehicle accidents?

DR. MISIK:

A. The answer is yes, I do, and just to give you some context, most individuals that come to me with injuries are usually the ones that suffer from some sort of soft tissue problems and have tried various things in the few days after the incident, and a lot of people I might not see at all, but the ones that I do see are usually individuals

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that will go on for four or six months with the type of scenario that you outlined, and it really not only affects them as individuals in terms of the inability to do daily chores of normal living, which again impacts significantly on their family, on their children, in particular, when they're small, and it also impacts their husband who has to take over the reins to a greater extent, who is already stressed from his work and then has to come home and help out his wife, and I am just – I don't want to generalize. I mean, the reverse obviously can be true as well that the wife may be the primary caregiver, and the father has sustained an injury and he really is not in the position to do all the things that were done by his wife because most of the time, obviously, the wife looks after children and so on, and that becomes a very frustrating thing day after day after day. What we see most commonly is something that really the industry does not see, and I'm talking about the insurance industry, and that is the after effects. Even when individuals have

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settled whatever they have to settle, we often see the subsequent problems that you referred to in terms of depressive disorder, which is increasing significantly for these type of injuries, fibromyalgia, chronic muscle pains and aches that are not explained by any other thing than just having had a particular traumatic incident, which obviously a motor vehicle is, so that the reason why I feel I should be here giving some further context is that we see those type of things years and years later that keep on cropping up, and we also see people 14/15 years later that are still having significant problems from their original soft tissue injuries. Just to say these are minor sprains and strains is really – does not make any sense to me whatsoever because these statements here are really as broad as they're short in their definition, and they don't really expand what actually is being seen out there in the community in terms of the medical practice.

(9:15 a.m.)

MR. FELTHAM:

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Q. And speaking of what you're saying is captured by the definitions that you're referring to of minor injury, as a medical doctor, in your opinion, do you consider this to be minor?

DR. MISIK:

A. Well, again the term minor in my opinion should not be there at all. There should be a different classification, as already has been talked about, Type 1, Type 2 injury perhaps, and so on, but to consider minor being the definition really begs the question then what does major mean, and major, are we talking about individuals that have substantial brain injuries, broken bones and so on, but there is a gradation of that, and minor, in my opinion, does not exist because as I said, again people may feel somewhat better after two or three months and so on of physio or whatever treatment one prescribes, but it's the aftermath and the symptoms that relate to mental health that come as a result of the trauma. Trauma, in and of itself, creates significant mental health issues in a great

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proportion of these individuals down the road, and that is not captured anywhere in these definitions, but yet it is a problem that we deal with on an ongoing basis, and it is a rather difficult to deal with.

MR. FELTHAM:

Q. And, Doctor, the mental health aspect that you're bringing up, I note that when I look at two of those definitions of minor injury in New Brunswick and PEI, PEI, for example, being the most recent, "A sprain, strain, or whiplash injury, including any clinically associated sequelae", and those could presumably include mental health effects, psychological injury, depression. What kinds of those patients or situations have you seen involving folks with motor vehicle accidents?

DR. MISIK:

A. Well, I read that statement as well, "including clinically associated sequelae", and no doubt they're recognizing obviously that there is more to just sprain and strain and so on, and, therefore, they've included that, but again it's the time frame that

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gives me problems because these sequelae are not just sequelae that are captured and then dealt with in a short period of time. They are not. They're ongoing, and they do continue, and they're very, very difficult to deal with. Most of these individuals often are predisposed to some of that, anyway, but they may not have any of that come to the fore until such time that a traumatic event occurs, and that's often the trigger not only for mental health issues, but also the trigger for physical issues such as, again I point out fibromyalgia, and whereas fibromyalgia in the days that I graduated was rather poo-pooed upon, there is now considerable evidence that that is a definitive entity, and in most instances it begins with a traumatic event, and this is certainly considered a traumatic event.

MR. FELTHAM:

Q. And do some of the, or have some of the motor vehicle accident injury patients that you have treated over the years, have some - in the months that they've suffered from the injury, have they developed depression and

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anxiety related degradations?

DR. MISIK:

A. Absolutely. That's my point, that the sequelae, and I would say a great majority of anybody that comes to see me again, has not had a minor – well, these are individuals that have had an unexpected most of the time rear end injury, and the unexpected part is that they were not ready for that and they have this hyperextension injuries which obviously has affected all of their musculature, and that is again a difficult thing to diagnose, but with experience, we do understand that these things go deeper than just muscular injuries, and they, in fact, in a lot of instances cause sometimes short-lived anxiety because they're always looking in the rear view mirror, and then oftentimes I've had incidents where I actually tell my patients 50 percent of the time, you need to look in your mirrors, and the other 50 look ahead, but I think most of these individuals tend to be 80 to 90 percent looking at the mirror, and they forget about looking ahead,

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so we've had secondary accidents.

DR. MISIK:

A. But, to your point, most of these individuals, or a great majority of these individuals, develop some sort of anxiety, stress, panic attacks very commonly. They become insomniacs in a lot of instances, which again affects their ability to work the next day effectively.

And the thing that is also forgotten in this is while there's compensation in the first period of time for individuals that lose time from work, in a lot of cases when individuals settle even after three, four, five, six months, they have ongoing issues with insomnia. They have ongoing problems with their soft tissue problems, so much so that we don't even see the times that these individuals take from work, which may be periodically, but over time, there's no question that these individuals have to take some time off and they usually use their holiday time or whatever they have at their disposal and it creates a lot of problems for the employer. So, it's a vicious

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circle. Everybody's affected by this.

MR. FELTHAM:

Q. Doctor, the second point that you brought up in your summary document that you provided was – well, maybe the easiest thing for me to do is to just reflect it back to you, but you noted that "the pressure that a legislated minor definition be put on the medical profession, general practitioners, ER staff, specialists, diagnostic services, et cetera, both from a patient volume and a financial perspective by injured accident victims who would be required by the legislation to establish that their injuries are of a degree so as to rise above the minor definition, this will no doubt lead to substantial increases and request for more medical and medical therapy appointments, more diagnostic requests, such as CT scans, MRI, x-ray, et cetera, et cetera, and an uptake in the insistence on referrals to specialists, with ultimately the cost for same being downloaded back on the health care system budgets."

So, here you're speaking of increased

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costs to the medical system in the province, and I guess ultimately to the citizens of the province as that flows through as a result of these minor injury caps. What are your views in that regard?

DR. MISIK:

A. Well, I believe it will create additional pressure, not only on government resources, for the reasons that I've outlined here, and namely that if and when they rise above that minor, they will undoubtedly, in most instances, continue to have ongoing problems, so much so that, you know, as you say, further services will be needed in order to deal with that. And then, on the other hand, if that happens, we will be inundated with forms to fill out and so on, and most of these services are non-insured services, so that it puts pressure on the individuals because they have to pay further for making out these forms, which are often quite detailed and lengthy and you have to go back and review everything so that you fill out the forms appropriately.

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So, yes, it will cause increased resources from the Department of Health and from the province in general and also increasing costs to the individual that has been injured and that can be substantial, particularly if these individuals from time to time then have to take time off and go on short term disability. So, yes, there is a massive potential increase in using of resources in many ways.

MR. FELTHAM:

Q. And what we're talking about here, I believe, is the patient, the individual who comes to see you and says "Dr. Misik, the insurance company says I can be only compensated $5,000 for this. I've been suffering with this for months. I have these problems. I need – you need to get me in to see the orthopedic surgeon." You need to do X, Y and Z because in their view, their claim is not a $5,000 claim?

DR. MISIK:

A. Well, and probably not in their view or in my view. I don't think that, from my perspective, despite the fact that all other

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provinces seem to be going that route, I think a key word that you've mentioned a few moments ago that I think where most people are behind the eight ball and do not look to the future because they're stuck in these old definitions and quasi-research that is usually paid for by the sponsor, but they're not looking ahead because medicine is going towards very individualized medicine, both genetically, from a genetic standpoint and from every other standpoint, and my particular comment in number six, if you look to my letter, is that there's a huge shift in our profession that is occurring based on individualized medicine, and I happen to be involved in a fair bit of genetic research and I think the industry is lagging behind.

Because again, in this particular instance, when we're talking about motor vehicle injuries and so on, it's absolutely impossible to lump everybody under the same umbrella because that's not what we deal with on a daily basis. We deal with

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individuals and every individual has different pain thresholds. They have different problems. They have pre-existing issues that impact how you treat the individual.

So, I really think we're stuck in the '90s and around 2000. We have to look forward. And I think this province, by trying to circumvent what the industry is trying to do are in fact more progressive, in my opinion, than some of the other definitions because everybody is just following whatever everybody else has done. But I think that's not where I think medicine is going.

MR. FELTHAM:

Q. And you mentioned -- I guess this is a similar vein in number three on your summary document, that the notion of artificial limitations or treatment protocols that are sort of a one-size fits all, I guess. How does that match up with your individualized medicine views?

DR. MISIK:

A. That's what I'm saying. It's really not in

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keeping with present thoughts about medicine in general and that's not only in the genetic field, it's in every field, because we are now in an era where individuals are the prime person that we have to deal with, not whatever somebody else tells us needs to be done in general. We will limit your compensation to whatever because it's considered minor, which doesn't mean anything, in my opinion. Minor doesn't mean anything. It's just very broad term.

MR. FELTHAM:

Q. And Doctor, if we look at number four on your document, you speak of consequences. Again here I think you're referring to cost consequences to the medical system, the physicians' time, that sort of thing. But you say "consequences of injured accident victims who having received a minimal cap payment are then on their own to fight for Section B coverages" -- and we're talking about medical benefits, disability payments under Section B in the insurance policy – "given the absence of legal advocacy in a capped claim process".

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So, correct me if I'm wrong, but you're talking about the claimant who takes their $5,000 payment from the insurance company. They don't have legal representation as they do in the present system to assist them dealing with their accident benefits claims and so on. Now they're turning to the physician to fill in that role? Is that correct? Is that what you're referring to?

DR. MISIK:

A. Yes, absolutely, and you know, while it may be coming off your back, it'll go onto the back of physicians and we will deal with much more serious issues because they continue to have problems. They're capped and yet, they are not in a position to pay for a number of things that are still necessary probably. I'm not talking about that they need to go on with physiotherapy or treatments forever. You know, there's simple remedies. But the underlying anxiety and stress and worrying that they could all of a sudden, by doing a simple thing – for instance, in the summer, I mean, I just know on several occasions, once the weather

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improved and people that had previously had an accident, all of a sudden they go out and they do a day's work in mowing their lawns and before you know it, they are in agony again because they had pre-existing problems from their soft tissues injuries, and that is an example. What do they do at that point if they've exhausted all of their Section B and they've been capped and they still need some sort of treatment? That creates a lot of stress on the family because then the individual that has done the mowing of the lawn, they're affected then by not being able to work for a few days. So, it's a constant ongoing issue and just because they've had no problems for two or three months and they feel fine doesn't mean that a small trigger could start the whole process again. And that happens quite frequently.

(9:30 a.m.)

MR. FELTHAM:

Q. Okay, Doctor. Thank you very much.

DR. MISIK:

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A. You're welcome.

MR. FELTHAM:

Q. There may be some other questions for you from some of the others.

DR. MISIK:

A. Sure.

CHAIR:

Q. Thank you, Dr. Misik. Mr. Gittens, do you have any questions?

MR. GITTENS:

Q. Thank you very much, Madam Chair. Dr. Misik, I think there is no issue in terms of us accepting the degree to which you've been involved in the practice of medicine in this province and the number of clients you've seen over the years. When you say to this Board that the use of the word "minor" is not helpful, I take it you're referring it in the context of what you have to deal with when you see a patient, as opposed to some artificial definition that might be added to the word "minor" in the context of what we're doing here.

So, part of what you said when you were presenting was at one point you mentioned,

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you know, there are people who after two to three months – a person may feel better after two to three months but still have long term consequences, including possible mental health issues and so on. Is there, in fact, in the medical profession, some sort of a cut-off point when if we don't want to use the word "minor" there is some less severe prognosis or less severe diagnosis, shall we say, of the level of injury? Is there such a medical expression?

DR. MISIK:

A. Again, you're referring to a global kind of definition for individuals and again, to go back to my point, individualized medicine does not deal with that because there – anybody that comes to my office will not be minor. There are a lot of people that have motor vehicle accidents that I never see.

And again, I just want to emphasize here that I speak for myself and for my own practice and not on behalf of the Newfoundland and Labrador Medical Association and/or behalf of the Canadian Mental Association. I speak on my behalf

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and my experience and I am very progressive in my thinking. I've been involved in research for so many years and I don't use that definition in my own mind. It doesn't come to the fore.

It's every individual needs to be treated differently, even though the accident may be similar. You can have a minor injury and people have serious problems. You could have a big massive car accident and some people just walk away, don't have any great problems. But I have to deal with whoever comes to my office and I often think that the condition is not so grave to begin with, but over a period of weeks, you often see a progressive kind of problem. Because as all of you know, oftentimes the first day or two, people don't have any major issues, although by definition if they have serious problems immediately, it's more likely they will have a lot of problems. But, on the other hand, you often don't see individuals for days. I've had people that have had no problems and three weeks later, they came in and they

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were off for six or seven months because of their soft tissue injuries.

So, the definition of minor does not come to mind at all, and when I saw that, I said "what does minor mean?" It's – you deal with an individual. You don't deal with a group because they've had similar incidents. So, I don't look at it that way from my perspective. That's all I can say.

MR. GITTENS:

Q. Okay. Understand that from the manner in which you practice, but I'm also concerned that there are, of course, treatment protocols that I take it physicians follow and when someone presents themselves and they say "well, I've got a pain" as a result of this incident, motor vehicle accident or otherwise and depending upon the area that they point out to you, isn't there some form of protocol that has to be followed in terms of dealing with that?

DR. MISIK:

A. I don't know of any protocols. I know what the research shows and so on. You know, most of these should go through a course of

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pain management, possibly the physio, massage and so on, and I use a lot of these. But again, I don't follow any protocol. I follow what I think is right for my individual. And I've done that all my career and I have had no issues or problems with following my own dictate in terms of dealing with whomever comes across the door. So, I don't follow protocol. Again, I individualize. Some people may need nothing and some people may need consultations to pain management group in St. John's and good luck that you can get somebody within a year or two. So, you know, you have to deal with people within the context of what's available in the province and deal with that. As I said, again, individual per individual.

MR. GITTENS:

Q. Okay. So therefore, I guess at the bottom of what you're saying here is the use of any definition that has the word "minor" in it will not be helpful in the context of what you have to do?

DR. MISIK:

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A. Correct.

MR. GITTENS:

Q. All right. Let's move on from that and obviously the proceedings before this Board are essentially directed at determining whether or not the current cost structure, in terms of the insurance industry carrying certain costs for the rehabilitation of injured people versus the medical system carrying those costs or the individual carrying those costs. That's the ultimate decision that this body will have to grapple with from the evidence it's heard.

But you've brought up the context of if there is a process by which a definition for minor injury or some other definition is used as a means of putting a cap on people's injuries or people's recovery, the medical profession will then have to bear the consequences of determining whether or not those definitions apply or whether or not there is a challenge then to try and get out of those definitions. Do I understand that to be what you're saying?

DR. MISIK:

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A. Yeah, that's correct. It's a challenge then more for the individual that has been afflicted by the problem and clearly puts pressure on the medical system because we will see those individuals much more often subsequent to the fact that they may have gotten whatever, and that's not an issue that I deal with, but it will put significant pressure on us, there's no question, and on the individual more so than the medical profession. That's what bothers me, because it's, again, the patient, the client or the individual that's been injured that will suffer, not only physical, mental, but also significant financial burdens.

MR. GITTENS:

Q. Okay. I understand, depending upon how we frame the question as to the bearer of costs for incidents or for injuries, whether it be the insurance industry, the individual person or the medical industry, that is essentially a bottom-line of what's going on here. But when it comes to you having to deal with these patients, do I understand you to be saying that, and I know I don't

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want to put—force you to put a number or a percentage on it, but to the best can assist the Board, in terms of these people appearing before you for medical treatment, it is not just a question of if there's pain management to be done or something, some diagnosis to be made, there are long-term consequences that, as you say, pop up 15, 5, 6 years later that have to be dealt with as a result of that particular incident. Can you give the Board some context, some sense of the number of patients, and I—while I realize it's going to be anecdotal, from your perception of the number of people that you deal with, and say per 10 or per 100 as the case might be that have these long-term consequences?

DR. MISIK:

A. Well, I would say that if I see 40 to 50, approximately, individuals per year for motor vehicle accidents, and I will probably say in the year 2000 some out of the individuals out of those 40 there will probably be 3 or 4 individuals that after often a year or two of treatments and so on,

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but at some point they just want to get on with it. And I encourage people to get on with it because it does have a positive impact in some way, but only, only if I feel that they have gotten back from a physical standpoint at least to where they were prior to, in their opinion and in my opinion. But I see consequences I would say out of those 40 to 50, there may be 4 or 5, that I often see six, seven, eight years and some beyond that that all of a sudden because of a secondary incident that may not be a motor vehicle accident, it could be anything, lifting furniture to move house, anything of that nature, that can trigger things again. And then, they are impacted again for months and months. So, I'm not sure that that's the right percentage, but I do see these individuals yearly that have had problems a lot time ago. And if at all they have a second accident, and that happens frequently, not only a second, a third one, they're often impacted for years and years and years beyond.

MR. GITTENS:

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Q. Okay. So, while you've put something of a percentage on it, you're not claiming that to be an accurate percentage, but it's just a sense of, out of your 40, you might have 4 or so that may run into several years of consequences. Let's take the reverse of that situation. It's an urban myth whenever one deals with people who have been injured in motor vehicle accidents, that the moment a settlement comes through, they can walk out of the lawyer's office dancing and doing a jig, and they no longer hurt because you know, these people have been essentially faking it until they get dollars and cents. In terms of your practice, are you ever aware as to when the people may have settled their claims and are you aware as to whether or not they continue to see you after those settlements have taken place?

(9:45 a.m.)

DR. MISIK:

A. I think the key word that you mentioned is "myth." And while some people feel content and happy and so on at that point in time that they don't have to carry on with seeing

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their lawyer, et cetera, for—to settle, I hardly ever tell individuals, "Look, I think you're going to be fine if you settle that," because I truly always give everybody the opportunity to say, "Look, you've been feeling fine and you've been doing well. Give it three to six months because you never know." And in the—and in a lot of cases something does happened in those three or six months. And going back to the myth, yeah, that seems to be what I hear all the time, but in my experience, there are quite a substantial number even after settlement continue to have ongoing problems. And I'm not talking necessarily of physical problems, but just I know a number of individuals that are afraid then to on the highway, they're afraid to go in traffic, they are substantially affected from a mental health perspective. They continue to have insomnia. That may not be seen as an important issue, but it is significant to that individual and the family. So, there are significant mental health issues that continue unabated despite the fact that they

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feel better physically at least for a period of time. So, I consider it a myth because I see so many people afterwards that still have problems, and they're looking for medications to sleep because they can't. And then during the day, they fall asleep at the wheel. So, there's a lot of issues beyond settlement that still go on.

MR. GITTENS:

Q. Finally, what I want to ask you to develop a little for us is you mentioned that the medical process in the province, and you I think are at the forefront of this individualized medicine, and then you commented that the approach taken by the other provinces in terms of having this one-size-fits-all, the cap for instance, is not as progressive as this province is. Can you explain? Give us a little more detail in terms of what you're referring to there in the comparison of this province with the other Atlantic Provinces and the approach they've taken to the insurance industry's request for caps.

DR. MISIK:

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A. So, here's my take on this. Number one, there is no medical protocol or process. You know, there's certainly guidelines that have been established, but they're guidelines. And what guides me is my patient. When I talk about the fact that—and I'm again, speaking for myself and not the medical profession as you refer to it. I speak for myself as an individual practitioner. I know, and I read every day, I read research articles, I read from a variety of excellent medical resources, and I know that within ten years it is all going to be individualized medicine based on genetics. And believe you me, there are genetic components to pain and pain thresholds because there are areas on the genome that deals specifically with response to any pain or discomfort and so on. And that is not only for pain management; that goes for every disease that we currently know. Every day of the year there are ten new tests, 365 days a year, that are going to be—that are being developed to test for various genetic conditions, including things

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such as pain. And where—why is one individual able to put their hands on a hot stove and not feel any pain, and the other one does? So, it's because of your genetic makeup. So, while I'm somewhat distressed that again the insurance industry has this global approach to deal with so-called minor injuries. In my opinion there is no such thing. It's individual treatment. I think the medical profession here is again slow to catch up with that, but I'm somewhat progressive in that area because I feel--and I've studied genetics considerably. We have very few actual geneticists per se in the province. And there is a significant link that in fact when you look at families, you will see that some individuals can be very stoic, and they do not even accept the fact that they've had an injury or pain and so on, and other who are completely the opposite. They will come to you immediately with what they or I might consider very little in terms of pain, but yet these things are ongoing, even with minor accidents. And some of those individuals,

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as I said, even with minor accidents will have problems for several years and develop mental health issues as well because again they're predisposed to that. So, you cannot lump. And the reason I say that we or I am more progressive because I look at it from an individual standpoint and not from, you know, a cookie cutter type of thing, that everybody has to fit into that. I do not agree with that, but that's my individual opinion and as I said, I do not represent the Medical Association on this issue and/or any association. I represent myself and that is my opinion.

MR. GITTENS:

Q. Thank you very much. No further questions for Dr. Misik. Thank you.

CHAIR:

Q. Thank you, Mr. Gittens. Mr. Fraize?

MS. FRAIZE-BURRY:

Q. We represent Spinal Cord Injury. So, in that regard I'm going to pose a hypothetical to you, if you don't mind.

DR. MISIK:

A. I'm sorry, I can't hear you too well.

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MS. FRAIZE-BURRY:
Q. Oh, is my microphone up? Okay, I'll get really close to it. So, we represent Spinal Cord Injury Newfoundland and Labrador. So, in that regard, I'm going to pose a hypothetical to you. A person with a spinal cord injury or other mobility impairment suffers a WAD 1 whiplash injury or say another similar minor injury. How would this impact a person with that type of pre-existing condition that they—that wouldn't, say, impact the rest of the population comparatively?
DR. MISIK:
A. So, if I hear you correct, you're saying that somebody that has a previous spinal cord injury –
MS. FRAIZE-BURRY:
Q. Or other mobility impairment; not necessarily a spinal cord injury.
DR. MISIK:
A. Right, and they have a secondary whiplash, hyperextension injury?
MS. FRAIZE-BURRY:
Q. Yes.

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DR. MISIK:
A. I think it clearly will impact them significantly.
MS. FRAIZE-BURRY:
Q. Yes.
DR. MISIK:
A. No question, and these individuals are already compromised significantly from an immune response perspective and from the fact that they are usually not mobile. So, yes, any additional injury and so on is clearly going to have more of an impact that it would on a healthy 25-year-old that's exercising and is fit. Absolutely, major impact.
MS. FRAIZE-BURRY:
Q. So, it would be fair to say their quality of life would be drastically changed?
DR. MISIK:
A. Well, they already have a very poor quality. So, to just add to that is adding to injury, and it's certainly not a nice picture. It will definitely affect them considerably. And we're forgetting about that fact that, yes, that is absolutely correct, but what

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does it do to the rest of the family? And that's not really taken into consideration here. Because at that point, be it a woman or a man that's afflicted, the partner as well as the children are significantly affected, and just adds insult to injury. It's just—that's just a horrific picture that you're painting really under those circumstances.
MS. FRAIZE-BURRY:
Q. Yes. So, it's fair to say that something like that would absolutely not be minor?
DR. MISIK:
A. No, absolutely, because there is so much problems already. It was definitely never be minor, and likely the injury itself would be more substantial because anybody that is impacted and already has very little mobility, to have that hyperextension injury is just going to be horrific and yes, absolutely that would be major in my opinion.
MS. FRAIZE-BURRY:
Q. Okay.
DR. MISIK:

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A. If "major" is a term that we can use.
FRAIZE, Q.C.:
Q. There's one further question. Have you noticed in your practice that when a senior, when I'm talking about a senior, let's say between—over 75 has an injury, the effect on that senior sometimes is far more than on a younger person? Would I be correct?
DR. MISIK:
A. You bring up a very, very good point, and speaking to that point, as you probably have guessed, I am considered a senior, and therefore –
FRAIZE, Q.C.:
Q. A lot of us are.
DR. MISIK:
A. - my practice has evolved over the years.
FRAIZE, Q.C.:
Q. Yes.
DR. MISIK:
A. And individuals, 2500 babies that I delivered over a course of time doing obstetrics, they have now grown, and I see them, and I see their parents obviously more so, because they're in the age group that I

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am comfortable dealing with at the present time. So, absolutely, what you're pointing out to me and I omitted to put that in my comments because seniors, anybody 55 or over or whatever the definition is, but I'm just talking about the elderly that have, most of the time, illnesses that are ongoing. They're diabetic, they have cardiac problems and so on. For them to have in addition to that, a motor vehicle injury and so on, put significantly more pressure on those individuals. They have significantly more problems. Their mobility is less. There's so many factors that come into play, when they're already are on 10, 12 medications for various other things, and then have to have, on top of that—that's what I see a lot of. And for anybody to say that any of their injuries are minor, just doesn't cut in my opinion. These individuals that are senior have much more problems than a young individual. So, your point is well taken, and I should have pointed that out earlier.

FRAIZE, Q.C.:

Q. Now, I've noticed in my practice when

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dealing with seniors--you've mentioned depression. And I've noticed that's come up a couple of times in the reports. The accident itself, the insurance company if going to call it minor, but the effect on the individual because it affects their mobility, and I'm thinking of one particular individual who was a runner. He had this, what they called a minor injury, but because of the physiotherapy and massage over a couple of years, I don't know, a hundred treatments or so forth, affected their ability to run. And that was one of their major quality of life things they like to do. And they suffered major depression. In the case I'm talking about, luckily the person came out of it, but it affected their ability to do what they were doing. So, that's I assume what you were referring to earlier in your evidence about this depression and anxiety that flows out of these types of things?

DR. MISIK:

A. Very much so. Not again, just on the individual, but on the family. And I think

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one tends to forget that, yes, the individual is the one that had the accident and continues to be depressed. That sort of filters throughout the family, and it often is the case that you actually end up treating the family members as well. There are very few, but I know of some individuals that have been very active physically and so on, and were runners, that somehow again because of their predisposition, what I consider fairly significant accident, and injuries and so on, are very again stoic and can get back to running in four to five months later, and they just work it off somehow. So, those are few and far between, but those are individuals. As I say, they're all individuals. They all have their own makeup and some deal with it better than others, but in general, the elderly population have much more difficulty than the younger individuals.

FRAIZE, Q.C.:

Q. So, you agree you take your victim as you find it? Basically, you can't put everyone in the same box?

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(10:00 a.m.)

DR. MISIK:

A. That is the principal point that I want to make, is that you have—this is individual medicine. Nobody should be put into a cookie cutter and say, "This is minor, and therefore that's where the buck stops." It just—that's not reality.

FRAIZE, Q.C.:

Q. Thank you, Doctor.

CHAIR:

Q. I thank you, Mr. Fraize. Mr. Stamp?

STAMP, Q.C.:

Q. Yes, thank you.

CHAIR:

Q. Thank you, Mr. Fraize. Mr. Stamp?

STAMP, Q.C.:

Q. Yes, thank you. Dr. Misik, you haven't spoke about this issue but I'd just like to inquire about it a little bit. Tell me how you became engaged in this process?

DR. MISIK:

A. Engaged in what process?

STAMP, Q.C.:

Q. Well how you arrived here this morning.

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DR. MIKIK:
A. Oh, yes, I frequently correspond with the legal profession on accidents and injuries that come from those accidents, and as you know, oftentimes the legal profession asks for medical documents as to what happened and how the individual progressed and where they are, and then I usually make a general summary at the end of my points to sort of zero in on the key things. So the reason why I came here is because I guess a number of individuals that I have written letters to have probably recognized that I, in particular, am very much on individualizing everyone and I think my letters are detailed enough that they feel that I have something to add to this process here, and really point out the importance of, again, individualizing things, rather than everybody being in the same ballpark.
STAMP, Q.C.:
Q. I guess in fairness, Dr. Misik, I guess all general practitioners are writing the same kinds of letters that you're talking about, are they not?

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DR. MISIK:
A. Absolutely, absolutely.
STAMP, Q.C.:
Q. But they're not here; you're here. I'm just wondering how you got here.
DR. MISIK:
A. Well I got here because somebody asked me would I be willing to give my commentary on my practice, the way I look at things and so on, and I said absolutely, because I would be very frustrated if there were any other ways of dealing with motor vehicle accident victims than we currently have, because at least it gives us some leeway to be able to treat those individuals adequately, but if the opposite occurred, I think we would have additional financial implications to everybody that is involved in the process.
STAMP, Q.C.:
Q. So who particularly asked you?
DR. MISIK:
A. In particular, Mr. Marshall.
STAMP, Q.C.:
Q. Okay, and so did you meet with Mr. Marshall about all of this?

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DR. MISIK:
A. No—well, sorry, he called me a few months ago, asked me if I would be willing to sit down, because he knows I correspond with him and his team on many occasions, and I'm not, I don't travel in his circles or social circles or anything, he just asked me as a medical practitioner that he knows, and I said yes, sure, I would be willing to give my thoughts and opinions and we had a discussion about that a few days ago. I did not know when this was going to take place, so I put my points together over the last three or four days, and then I had a one-hour meeting with him yesterday to flesh out my thoughts a little bit more, and that's why I'm here this morning.
STAMP, Q.C.:
Q. So he phoned you, what, did you say a month ago or so?
DR. MISIK:
A. No, no, it was early in the summer, I think, June or somewhere around there.
STAMP, Q.C.:
Q. Oh, okay, a couple of months, two or three

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months ago. And how long did that call take, Dr. Misik?
DR. MISIK:
A. We spoke on the phone while I was travelling in the car, so it must have lasted about five, ten minutes.
STAMP, Q.C.:
Q. Okay, so that was the introduction to the discussion that you had with him.
DR. MISIK:
A. Yes, absolutely.
STAMP, Q.C.:
Q. And did he provide at that time, on that phone call, any detail of sort of what he was hoping you could provide to the process?
DR. MISIK:
A. Really, to be quite honest with you, until yesterday I did not realize, number one, I had seen these definitions somewhere in the past, because these are ancient definitions to be frank, and yes, I didn't even know what it meant to, where the cut-off was, what the amount was, I didn't know any of that until yesterday. I'm actually not that familiar with Section B or anything like

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that, I don't deal with all that stuff most of the time, except when I have to fill out forms and then it's just to fill our forms, but I don't even know what Section B covers and what every individual has under Section B, because it's really of no importance to me. My main focus is on the individual that I treat and all the other financial issues I don't deal with. I have no idea whatsoever at any time with any of my patients what the amount was that they settled for, whatever, I never get into those discussions. I have no idea and I couldn't care less.

STAMP, Q.C.:

Q. Right. Well I'm just trying to make sure I understand. So you had the phone call and then you met with Mr. Marshall yesterday, is that the understanding? Am I correct about that?

DR. MISIK:

A. That's correct.

STAMP, Q.C.:

Q. So this is the 7th, you met with Mr. Marshall on the 6th?

DR. MISIK:

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A. Yesterday, yeah, the 6th.

STAMP, Q.C.:

Q. When did you actually write the letter that we're looking at?

DR. MISIK:

A. I wrote the letter, well it was dated for today, but it was three, four days ago because it must have been Monday because I got an email, I think, from Mr. Marshall I think on Sunday telling me that the meeting was held this week which created a little bit of a panic in me because I just sold my house and I'm in the process of moving and there were all kinds of things going on, and I said, look, I can put together my thoughts and when is the date for the meeting, so I put down September 7th, but this whole thing took the last four or five days to put together. But really, there's nothing here that requires a genius to put together, this is all bread and butter for me.

STAMP, Q.C.:

Q. Okay, but I'm still trying—I'm just having a little trouble connecting the dots here, so –

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DR. MISIK:

A. How so?

STAMP, Q.C.:

Q. A few months ago you had a phone call from Mr. Marshall, in the car, a brief discussion, maybe five or ten minutes you say.

DR. MISIK:

A. Correct.

STAMP, Q.C.:

Q. And you met with him yesterday for about an hour.

DR. MISIK:

A. Yes.

STAMP, Q.C.:

Q. You had an email a few days ago or two days ago or three days ago?

DR. MISIK:

A. I had an email, I think it was Sunday. I may be off by a day, but that triggered me to—then he said the Board required some sort of written document and could I put something together and submit to the Board here, and I sent it to him. We had a discussion about it yesterday and that's

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where we are.

STAMP, Q.C.:

Q. So we got this, I think maybe the day before—I'm not sure what day we got it. You wrote it what date did you say?

DR. MISIK:

A. I say on Monday.

STAMP, Q.C.:

Q. Monday, okay, and who did you give it to?

DR. MISIK:

A. I gave it to Mr. Marshall.

STAMP, Q.C.:

Q. And did you have any discussions with Mr. Marshall? I mean, did you give him an early draft and make some changes? Did he suggest some things to you?

DR. MISIK:

A. There were some punctuation and commas, et cetera, et cetera, that we looked over, we made the changes and on all occasions he sent it back for me to okay, and I did.

STAMP, Q.C.:

Q. I'm just curious about Item No. 4, this is early on in this piece and we'll be coming back to this letter a bit more, but you talk

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about this minimal cap arrangement and they'll be on their own, have to fight for Section B coverage, where did that come from in your own practice?

DR. MISIK:

A. Well I know that Section B covers a lot of these things. I don't know whether your Section B covers 20 physiotherapy treatments or 5 physiotherapy treatments, every individual, I presume, has a different plan, but I do know that Section B covers some of those and having been in a motor vehicle accident myself some years ago, I knew that I had to go through my Section B first if I was to use an ancillary treatments and so on, but I do not know that beyond physio and massage and so on, that there are other things that are covered, but I do know that once you cap that, a lot of individuals that may go on beyond two or three months of treatment do need some ongoing problems (sic.), so therefore I felt that if we, if that was capped, that these individuals would be in a situation where they would have to pay their own or whatever, and some

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of these individuals go on for a long time.

STAMP, Q.C.:

Q. So your concern is that Section B would be capped or that there is another cap?

DR. MISIK:

A. That these individuals would not be able to have any more Section B, so therefore, they would have to pay individually from their own pocket.

STAMP, Q.C.:

Q. I see, that was the point you were making here then?

DR. MISIK:

A. Yeah.

STAMP, Q.C.:

Q. Paying out of your own pocket instead of using Section B?

DR. MISIK:

A. Well, yeah, and the point being that on top of everything else, their physical injuries, their mental problems, they then have a financial problem if they are capped, if they go on to have further problems down the road. So at some point I know that there is a cap on these, but I'm not sure whether

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everybody has the same physiotherapy treatments they can get, I don't know what the limit is. I know that some of my patients often come in and say, look, I've gone beyond my—because I think everybody has different limits, depending on their employment status or whatever, I don't know.

STAMP, Q.C.:

Q. Okay, all right. But the point you're making in No. 4 is not a complaint about a cap, it's a cap particularly on Section B that you're concerned about?

DR. MISIK:

A. That's the point, yeah, I'm making.

STAMP, Q.C.:

Q. Is that the point you're making?

DR. MISIK:

A. Yeah, but I'm also concerned about a cap in general on anything, because why would anybody put a cap on somebody that, whether it's Section B, whether it's anything else, if they continue to have ongoing problems, despite the fact that they're considered, in the book, as being minor. There should be a medical cap. If I feel that somebody has

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six weeks and they've had plenty of physio, that any further physio is not going to help them, that they need to do their home exercises and so on, I will tell them. The other thing that bothers me a lot is that sometimes they go to physio and all that happens is passive treatment, and by that I mean, you know, somebody gets your back and neck ultrasound and heat treatment, which does nothing to improve them, so I would be much happier if somebody had active treatment, and in a lot of these cases, they may not need further treatment beyond six or seven weeks because they've reached their limit in terms of what you can do beyond that. But some individuals do, they do need further monthly, either massage or whatever, so if they go beyond their Section B, which is what I know covers those things and psychologists is something that's not thrown in there at all, but psychologists are being used more and more because of what I had mentioned is the mental health aspect and in this province, you cannot see a psychiatrist for two years, so we have to use

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psychologists, and when you throw in psychologists, you throw in physio and possible massage, it doesn't take long to go over whatever it is, $500.00 or $1,000.00, I don't know, I mean psychologists will charge you $100.00 an hour, it doesn't take long to, along with everything else, to breach that cap, whatever that may be. So I used "cap" because that's one of the caps that I know. I don't know what other caps, but there ought not to be any cap.

(10:15 a.m.)

STAMP, Q.C.:

Q. And is a cap, for example, on loss of wages, for example, a concern for you?

DR. MISIK:

A. Absolutely, absolutely, as I pointed out earlier, even in the current situation there are a lot of individuals after they have settled whatever the settlement is for, I don't know, whether it's $5,000, $10,000, whatever, they continue to have problems beyond that period of timeframe, and that never comes out as being something that is related to the motor vehicle injury in the

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first place, so to put a cap of any kind is ludicrous.

STAMP, Q.C.:

Q. Are you familiar with the concept of claims for loss of future income?

DR. MISIK:

A. Not really.

STAMP, Q.C.:

Q. Well if you read a report to Mr. Marshall –

DR. MISIK:

A. Well I understand what you're saying, I mean, it's a fairly logical concept, but I don't really know the ins and outs.

STAMP, Q.C.:

Q. So when Mr. Marshall asked you for a medical report and you write and he's interested in knowing, for example, if the patient, his client, your patient is going to continue to have problems, then I guess you express an opinion on that for him?

DR. MISIK:

A. I do, at the summary of my letters I always point out that at this point I either feel that this individual requires further treatment, further time off, is on short-

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term disability, long-term or whatever, and/or on the other hand, I feel that this individual has reached his or her maximum recovery and in summary I feel that this individual ought not to have any serious sequelae down the road. So I mean, that's if somebody –

STAMP, Q.C.:

Q. Sure, okay, all right. Well maybe you have answered my question. Just on that point of Mr. Marshall, you said you had an accident yourself?

DR. MISIK:

A. I did indeed, yes.

STAMP, Q.C.:

Q. Was Mr. Marshall your lawyer?

DR. MISIK:

A. Mr. Marshall was my lawyer for that. I would like to point out so that there is no misunderstanding, I have three lawyers that I deal with. One is Mr. Marshall, the other one is Mr. Denis Barry and I deal with Mr. Bob Simmonds on some issues, so I sought Mr. Marshall's advice because I knew that his expertise is in this field and that's the

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reason why I did, but I have not dealt with him in any other way, shape or form.

STAMP, Q.C.:

Q. But on your motor vehicle accident claim he represented you?

DR. MISIK:

A. Absolutely.

STAMP, Q.C.:

Q. Okay. So this discussion on, I'm back to Item No. 4 in your letter, did Mr. Marshall have any suggestions about this language in No. 4?

DR. MISIK:

A. Well, I think basically he told me that the proposal is to have a cap put on Section B, that is the treatment modalities that are used primarily in medical management, and I thought that the, if that were to happen and people would have to continue to right beyond that, that that would create significant problems and given the fact that they would not have any representation at that point to try to further their cause, that would be a significant issue.

STAMP, Q.C.:

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Q. But why wouldn't they have representation?
DR. MISIK:
A. Because I feel most individuals if they are capped would not even seek any representation, despite the fact that, you know, they have ongoing problems and it would be significant burden to them and possibly some individuals may try to get more time and more MRIs, more CAT scans in order to prove and get them beyond a cap, and I think, you know, that would put a further significant problem to the actual financial aspect.
STAMP, Q.C.:
Q. Well, we better try and clarify what Mr. Marshall told you. He said there's, he had a concern and told you about this concern on a cap on Section B, am I right about that?
DR. MISIK:
A. Yeah. Because, I mean, I had the same issue with Section B when I had an accident as well, and you referred to that as an example
STAMP, Q.C.:
Q. Right, did you reach a cap on Section B in your own circumstance?

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DR. MISIK:
A. I don't really know. I really can't remember and I—I don't know, but I just knew that there was a cap and quite frankly I don't really know what the cap is, but the fact that there would be a cap, as such, bothers me.
STAMP, Q.C.:
Q. But are you understanding, the system as it currently exists, whether there's a cap on Section B right now or not, do you know that?
DR. MISIK:
A. I know that a lot of individuals, beyond a certain point are not being paid through their Section B and they have to go beyond that and usually it is. What I do, I always tell the patient, look, at this point I can't do anything further for you, go and see your lawyer, and at that point, they even get further treatment permission through however the lawyer deals with that, but I don't get involved in that, that's not my role.
STAMP, Q.C.:

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Q. Which takes me back to No. 4, why did you get into this discussion in your letter about "they're on their own to fight for Section B", where did that come from? Did Mr. Marshall use that language?
DR. MISIK:
A. Well Mr. Marshall told me basically that once people get to that cap and they have no representation because most of them have no ability to fight for anything further beyond that if they are capped, then these individuals are there to fight their battle on their own, and that is, that is of a concern to me.
STAMP, Q.C.:
Q. So Mr. Marshall—this is Mr. Marshall's comment that you've adopted in your letter?
DR. MISIK:
A. But it represents my thoughts.
STAMP, Q.C.:
Q. Well it didn't, apparently, he told you what –
DR. MISIK:
A. No, no, it represents my beliefs that I think this would be to the detriment of my

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patient were this to happen.
STAMP, Q.C.:
Q. Right.
DR. MISIK:
A. And he explained there is, that there will be a cap and therefore I thought that that was totally wrong and I put that in there.
STAMP, Q.C.:
Q. And you understood him to say that it would be a cap on Section B, you thought that would be totally wrong?
DR. MISIK:
A. Yes.
STAMP, Q.C.:
Q. Okay, all right. So when you did the first letter and sent it to Mr. Marshall, did you have a No. 4 paragraph like this in there, or how did it come that you got No. 4 in there when he told you about this situation, which is at the meeting, I guess?
DR. MISIK:
A. He told me about the situation before, we had a telephone conversation and he pointed out to me what this whole process was all about, and then he puts—we emailed back and

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forth.
STAMP, Q.C.:
Q. Ah.
DR. MISIK:
A. Well we did, we did email back and forth and that was, not during the summer, we had a conversation first, somewhere in June, I can't recall exactly when, and then starting on Sunday, we started emailing back and forth in order to get something in that makes sense to me and this is something that I felt was important to put in there, that any cap, whether it be under Section B or any other cap, is in my opinion, inappropriate.
STAMP, Q.C.:
Q. But am I understanding you correctly that Mr. Marshall is the one who suggested this –
KENNEDY, Q.C.:
Q. Madam Chair, excuse me, I don't mean to interrupt, Mr. Stamp, but could I make a comment please? It seems to me we've been 20 minutes –
STAMP, Q.C.:
Q. Can I ask him to be excused before we do

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this, please?
KENNEDY, Q.C.:
Q. No, just one second –
CHAIR:
Q. Just a second, Mr. Stamp.
STAMP, Q.C.:
Q. Could I ask the witness be excused, Madam Chair?
CHAIR:
Q. Sorry?
STAMP, Q.C.:
Q. The witness be excused while this discussion is going on, would that be possible?
MR. O'FLAHERTY:
Q. Madam Chair, just as Board Counsel, I don't agree with that, I don't think that's appropriate, this is not a court of law in which the witness needs to be excluded, the witness can hear what's being said in my view.
CHAIR:
Q. I agree.
KENNEDY, Q.C.:
Q. Okay, my comment is quite simple. If Mr. Stamp is alleging that Mr. Marshall did

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something wrong, put it on the record and we can deal with that then. There is nothing wrong to the best of my knowledge with a lawyer talking to a potential witness. Mr. Stamp has his client, clients, sitting there next to him. They're obviously talking about, I would suggest, what's going on. If there's an allegation that Mr. Marshall has done something wrong, I would like for Mr. Stamp to put it on the record, put it there directly. Mr. Marshall will be here next week and he can deal with it.
CHAIR:
Q. Is that where you're going, Mr. Stamp or –
STAMP, Q.C.:
Q. No, my point, Madam Chair, Commissioners, is simply to understand what the background was to the presentation of this letter, the preparation of it, the presentation of it, what the background was to it. I think it's important for the panel to have that information.
CHAIR:
Q. Could you explain to me how it's important?
STAMP, Q.C.:

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Q. Well, if the letter was written, let's just— I know it wasn't, but if the letter was written by Mr. Marshall himself and Dr. Misik simply signed it, that would be important to know. What we're trying to see is to what extent Mr. Marshall, if you like, did not author it but suggested the topics to include.
CHAIR:
Q. Dr. Misik, this is your letter.
DR. MISIK:
A. This is my letter.
CHAIR:
Q. You signed the letter.
DR. MISIK:
A. The issue is, what Mr. Stamp is referring to, that I had conversations through email with Mr. Marshall so that we could clarify and for him to understand my feelings, I sent him after our conversation in June, a lengthy email and he, I'm sure, could be here providing you that email, I don't mind one bit, but it was a lengthy email, in response what he quickly outlined on the phone to me was the purpose of this hearing,

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and I gave him a point by point response that I felt from my practice would have an impact. Now, there was no specific mention of whether it's Section B or, so I just knew there was a cap, and I wrote him a detailed letter of my thoughts, including the last point which should have been the first point, actually, 6 should be No. 1, and then we had over the last few days, from Sunday, because I was totally taken by surprise that today was the day and we only had four or five days to put something together, and based on the lengthy email that I sent him in June and I can provide you with that if I had my iPad here, that's how I began this whole process and we then fleshed it out over several days, but these are my thoughts and my opinions that was discussed with Mr. Marshall and I agree with every one of these points.

STAMP, Q.C.:

Q. Thank you. Dr. Misik, the issue of the definition you spoke about, where you feel that the word "minor" is an inappropriate word, is that correct?

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DR. MISIK:

A. Yes, it's as broad as it is short, and it really doesn't tell you anything.

STAMP, Q.C.:

Q. So some other way of describing it would be more useful, you think?

DR. MISIK:

A. Absolutely.

STAMP, Q.C.:

Q. The definition sections which are at the bottom of the second page of your letter, can you tell me did they come from Mr. Marshall?

DR. MISIK:

A. Yes.

STAMP, Q.C.:

Q. Okay, and so you've spoken about, I guess some of the, your patient history, I guess, general patient history in your discussions earlier, and what I was sort of hearing you say, I thought, was more in reference to what I would consider to be non-minor injuries, more severe injuries than the minor that is, I guess, trying to be caught by this definition. But let me just ask you

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this, when you are looking at some of these issues, when you talk about somebody whose injury might be referred to as minor and yet they have some kind of, I don't know, substantial inability to perform their daily tasks, whether it's work or school –

DR. MISIK:

A. That's not minor.

(10:30 a.m.)

STAMP, Q.C.:

Q. That's not minor, okay.

DR. MISIK:

A. That's not minor.

STAMP, Q.C.:

Q. Or if they had some substantial inability to perform their normal activities?

DR. MISIK:

A. That's not minor. And again, I do not use that term, I don't like that term, and when you refer to that from my medical perspective, it does not make any sense.

STAMP, Q.C.:

Q. So if a patient has what you might describe as an impairment, maybe a substantial inability to perform work or attend school

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or do the training they're involved in, or engage in a normal activities of daily living, those would not be minor in your mind?

DR. MISIK:

A. Absolutely not.

STAMP, Q.C.:

Q. And particularly, I suppose, if it's not expected to improve substantially, that would not be minor?

DR. MISIK:

A. Correct.

STAMP, Q.C.:

Q. When you looked at the definitions that were provided to you, did you look at any—I mean, each of these definitions you have in your letter, a lot of them you never had.

DR. MISIK:

A. But I've seen these definitions before. It's not that all of a sudden that they came out of the blue. I've been familiar with these. I've never agreed with them. I never agreed with a term W-A-D. I think the Quebec task force definition does not make sense in this day in age whatsoever. While

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I use that in some of my correspondence, just to give some perspective, I think it's absolutely wrong to use that definition and there ought to not be a definition. The definition is that again, each individual has a different definition. And the definition revolves around the fact to what degree are they impaired, to how long are they impaired, how long they have been afflicted by continuing problems of panic attacks, anxiety, insomnia and there's no way that you can define that because while somebody may think that that's considered minor, another individual may consider that to be severe or major. So, to me, as I said, it's as broad as the definition is short without any meaning.

STAMP, Q.C.:

Q. Well one of the key features, I'm going to suggest to you, in each of those definitions that you have in your letter is--references serious impairment. And what each of these say is that it describes an injury that does not result in serious impairment. Doesn't that take care of some of the concern you

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have? If it results in serious impairment, then of course, you have a different issue.

DR. MISIK:

A. It doesn't really address my concerns. It's like, to use a colloquial, it's like a thermos bottle, how to know whether the thing is cold or hot. So, you don't really know, in a lot of instances where these individuals end up. It may seem that they feel fine, but then three months later again, because of the original injury, having done something that is normal and is a day-to-day activity such as mowing lawn, all of a sudden—and I use mowing lawns because I just saw somebody recently that again has had an injury several years ago and I know that what he sustained recently on the weekend is the fact that that came initially from an injury that he sustained through an accident. So, some of these things go on for a long time and then you have to treat that again for another month or two. So, I think the definition here you cannot put a cap, and I'm not talking about a financial cap, but you can't actually put

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everything in a box. Medicine cannot be put in a box.

STAMP, Q.C.:

Q. What do you understand is meant by the phrase "serious impairment" in those definitions?

DR. MISIK:

A. Serious impairment, again I'm again referencing the fact that serious impairment to one individual is not the same as serious impairment to another. That's why you have to individualize. You cannot put everybody in the same category. That's my personal opinion. It does not reflect anybody else. I want to make that clear again. It's not on behalf of the medical association and/or Canadian Medical—that is my personal opinion, having practiced medicine for 48 years in this province.

STAMP, Q.C.:

Q. But the Nova Scotia definition, for example, you have in your letter refers to a sprain, strain or whip lash injury that does not result in serious impairment.

DR. MISIK:

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A. And when do you know that?

STAMP, Q.C.:

Q. When do you know that?

DR. MISIK:

A. That's the point.

STAMP, Q.C.:

Q. Okay.

DR. MISIK:

A. That's my point.

STAMP, Q.C.:

Q. But at some point I guess—it's some point in time you understand when that occurs.

DR. MISIK:

A. Maybe, maybe—I don't know. I mean, that's my point when I tell you that I've seen individuals years and years later that I know the—and the fact that I've practice 48 years, I've seen these individuals as babies, I've seen them all their lives and they continue coming, so I know these individuals and I know when somebody actually, sir, is "fake news" rather than actually just being a substantial reoccurrence of their original injury. I'm experienced enough to know when these

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individuals comes and they try to pull the wool over my eyes. That doesn't happen. It may happen unknown to me, but I make sure that's not the case. And I can tell you there is no such thing here as injury that does not result in serious impairment. You don't know that –

STAMP, Q.C.:

Q. Will you ever know that?

DR. MISIK:

A. - because a serious impairment can occur years and years after.

STAMP, Q.C.:

Q. But isn't the claim that is handled today with these circumstances that we're talking about don't exist, aren't those claims addressed in one way or another and people resolve those claims whether six months or six years later? Don't they resolve them?

DR. MISIK:

A. I don't know that and I don't care. I'm talking from a medical perspective that they continue to have problems. And there is no such thing, at any given time where minor injuries over and done with. Yes. The

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individuals that I don't see and I know that I see individuals only that have impairment sufficiently serious that they need to have some help from somebody. But there are a lot of people that I may not see. I mean, there's a lot of accidents people just walk away and that's it and that's the end of it. I don't know that.

STAMP, Q.C.:

Q. How does it play out, Doctor, in your practice, I mean, how does that work? A patient comes in who has had a motor vehicle accident, whether it's the same day or three or four days later or a week later, they are in to see you and they got some complaint. That's why they are there to see you, I guess. Is that right?

DR. MISIK:

A. Absolutely.

STAMP, Q.C.:

Q. Okay. So, you conduct an examination, do you? Take a history.

DR. MISIK:

A. Well I think more than examination. The most important thing is a good history.

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STAMP, Q.C.:

Q. History, sure. And you may take an examination as well?

DR. MISIK:

A. May or may not. You know, again, it depends on the circumstance. Yes, in most cases, I absolutely have to perform physical exam. The findings are very often nebulous and may not mean anything at the time, but I may see them a month later and their restriction of mobility is increased substantially. So then you have to re-assess. You have to again, get something objectively in your notes that describes the change that you found. So, and then, whatever it takes, either treatment or whatever and then you follow these individuals. And you follow them until you know they've reached a plateau in their treatment and have reached a point where they feel comfortable again. And at that point I say, well look, hang on three to six months, don't do anything because we don't know how this is going to play out. Sometimes they end up having problems again because they have secondary

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issues from something else. So, I don't know that at the beginning. I don't know that when they even feel better, but they continue to have weakness, soft tissue, muscular problems that they don't feel at the time, but are re-aggravated by something. And it's not because—and it's due to normal things. And it always goes back to the—if they had not had the motor vehicle accident, it would be—if they have no problems and they're fine and they've had not problems in their family or anxiety, mental health issues or whatever, I tell them, look, I'm comfortable that you're okay, but sometimes I'm wrong. I see them two years later and they continue to have some sort of problems. So, you know, we're not God; we can only do what we can at the time, but all I'm telling you is that I never presumed that something is minor because minor means so many things and it means a different thing to different persons.

STAMP, Q.C.:

Q. Don't you and your colleagues ultimately

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have to decide where the patient is? You're going to be asked for an opinion, this is typically how things are figured out. I mean, the lawyers can't figure out what the patient's, the client's situation is medically. They rely on the doctor; same as the judges rely on the doctor, if it comes to that. So, the doctor or the practitioner, the medical, you know, practitioner, whatever that person is, is the—that's the basis on which the decisions are taken, I would suggest to you. You write a letter, like you talk about, you feel confident that the issues have plateaued and the person is okay. I guess you'll somehow capture that perspective in your letter to Mr. Marshall or others. And if you don't think that, I guess –

DR. MISIK:

A. Yeah, I'd like to point out that Mr. Marshall is not the only person that I write letters to.

STAMP, Q.C.:

Q. Of course not.

DR. MISIK:

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A. I write letters to lawyers all over the place, particularly on the Avalon Peninsula.

STAMP, Q.C.:

Q. I'm quite sure you do.

DR. MISIK:

A. Okay.

STAMP, Q.C.:

Q. But my point is that if you feel that the patient has plateaued and they've reached full recovery, I guess, you don't mind saying that in your letter. If you don't think that that has occurred, I guess you say that in your letter. Do you not?

DR. MISIK:

A. Absolutely.

STAMP, Q.C.:

Q. And so in some way you communicate to the lawyer you're writing to, this is where like the rubber meets the road here, you communicate to the lawyer you're writing to, I have these ongoing concerns because the patient has these ongoing symptoms and it may continue for weeks or months or years, you may indicate. Is that how it works?

DR. MISIK:

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A. Absolutely.

STAMP, Q.C.:

Q. And is that how it works right now?

DR. MISIK:

A. Absolutely.

STAMP, Q.C.:

Q. So, how is it going to work differently, you know, in 2019 if there's some kind of cap imposed?

DR. MISIK:

A. Well, I don't understand why every individual should be capped at a certain level without knowing what the longer term consequences are going to be. I'm in a much better position to be able to tell that after three, four, six months and a lot of people go on for a couple of years to become chronic. So, I have concerns for the individual.

STAMP, Q.C.:

Q. Sure.

DR. MISIK:

A. And I have concerns, as I pointed out, on the system because with caps we are going to be significantly affected by that in many

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ways in our offices. All these forms that normally I don't have to handle and so on are now going to come to us and so on. It's going to cost the individual because it's a third party insurer. So, I don't see what the benefits are for the individual by capping them.

STAMP, Q.C.:

Q. What I'm saying, I don't have any trouble with what you're saying there, by the way, you have to take time to decide what the patient's situation is going to be, but there's not urgency in that being decided, is there?

DR. MISIK:

A. No, absolutely none.

STAMP, Q.C.:

Q. And if there's a cap that's to apply, it will only be determined after that time frame you've required plays out and you can tell what the situation is going to be. Isn't that the case?

DR. MISIK:

A. Yes.

STAMP, Q.C.:

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Q. So, if it turns out that the patient has had a very good outcome, like some patients may have, that will play out over time and you'll become alert to that conclusion.
(10:45 a.m.)
DR. MISIK:
A. I will point out in my letter that I feel, at this point, that the individual has returned to their prior abilities to function and that I do not foresee any serious sequelae. And that's—when they've reached that point, that's what I tell—but that may be after two years.
STAMP, Q.C.:
Q. Of course.
DR. MISIK:
A. Absolutely.
STAMP, Q.C.:
Q. I understand that. So, it sounds like we're having a difficulty with the timing issue as opposed to what a cap should do or if there should be a cap. Your concern appears to be, somehow a person has got to decide right away or a decision is going to be taken right away that there's a cap applicable to

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that person when it takes months or a year or two years to really know whether that's the case.
DR. MISIK:
A. I'm not sure what your point in there because we've gone over that, absolutely.
STAMP, Q.C.:
Q. Well, I'm not sure why you feel that whether a cap is going to be imposed down the road, at the end of that conclusion interferes with your ability to manage your patient's care.
DR. MISIK:
A. But what I'm saying is that if you go on to have various treatments over a period of time and you're affected psychologically and mentally and how do you capture those symptoms under a cap because some of these are ongoing and will probably go on for years as a result of this accident. So, there's the mental anguish and all the things that are related to that that are not captured in any of these caps.
STAMP, Q.C.:
Q. But why can't all those issues that you're

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talking about be determined before the decision is made as to whether or not a cap will apply?
DR. MISIK:
A. Because you—all I can say is that from my perspective, at some point in time, either that individual goes on to chronicity and you can't do anything with that or you feel that the individual has reached his or her plateau and feels better and therefore, I feel—but then that doesn't take into consideration that this individual still has ongoing difficulties with their mental anguish, with their family being still affected that they can't drive properly. They're scared all the time to go on the road, somebody—so, how is that captured under a cap?
STAMP, Q.C.:
Q. Well, Doctor, isn't it the case really this way, that whether a cap will apply would depend on whether the injury fits a certain category or does not fit the category?
DR. MISIK:
A. Well, let's have a clear definition of those

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categories, rather than definitions. As these definitions do not fit into my medical practice. They don't fit me as an individual practising medicine in this province.
STAMP, Q.C.:
Q. But whether it takes six months or six years for that ultimate determination to be made, as to whether the injury fits into some sort of definition, even if the word "minor" doesn't appear in it, fit's in some kind of definition or category or does not fit, why can't that decision be taken, that six months or six years, whatever it takes to do that, there's no requirement that the decision has to be taken the first day or the first week or the first month as to whether a cap might apply on any aspect.
DR. MISIK:
A. So, you're telling me that after six years, you're going to decide that all those six years really what this individual is entitled to is $5,000.00, let's say.
STAMP, Q.C.:
Q. Well, actually, Doctor –

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DR. MISIK:
A. How do you determine whether at that point while this individual has been seen multiple times, has had multiple treatments, has had all these ancillary mental issues, how do you then decide that yes, that cap is going to apply versus now, I suspect that there is much more substantial recompense as a result of the additional anguish and the possibility that that may go on for a long time?
STAMP, Q.C.:
Q. I mean, people settle claims now, they do it all the time. I guess you did one yourself. So, they settle claims and no one can predict 10, 15, 20 years down the road, but they settle claims based on the best information they have at the time, whether that's under the new system with a cap, if it should exist, or under the present system. Those decisions still get taken, don't they?
DR. MISIK:
A. Um-hm.
STAMP, Q.C.:

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Q. And all you want to have is enough time, as I understand you, to make sure you've have adequate time to ascertain when you're dealing with that patient, what the situation actually is. Isn't that fair enough?
DR. MISIK:
A. Yeah.
STAMP, Q.C.:
Q. And so as long as you have that opportunity and I mean, it's the doctors who –
DR. MISIK:
A. Yeah, yeah.
STAMP, Q.C.:
Q. - really provide that data for us.
DR. MISIK:
A. Yeah.
STAMP, Q.C.:
Q. Once you have that opportunity, whether it's six months or six years or whatever the case might be that you need, that will ultimately decide, you'll ultimately decide then how that patient has fared, in—how to describe the patient's situation. Isn't that fair?
DR. MISIK:

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A. Yeah.
STAMP, Q.C.:
Q. So, you don't have to decide the cap issue today, next week, next month, 12 months, 24 months, you decide it when the doctor is finished with the care and the patient decides to settle. Isn't that a fair way of doing it?
DR. MISIK:
A. It is.
STAMP, Q.C.:
Q. Okay. I want to come back to a couple of pieces in your report. You talk about the pressures on the system. You say, for example, there'd be pressure on the medical profession based on patient volume and financial perspective. So, you have increases in requests for more medical, I guess, diagnostic –
DR. MISIK:
A. My point here is that a lot of individuals may try to push in order to get beyond the so called cap it will put extra pressure because those individuals actually will try and insist upon further treatments, will

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insist on more diagnostic—now, I'm the final arbitrator of that, you're absolutely right, but the point is, that the pressure will still be significant from some of these individuals and therefore put extra pressure on our system that's already full. And so I think there is going to be a fair bit of that pressure put on us because nobody wants to go with a cap when they don't really know. So, let me see a consultant; let me see can I get a CT scan, can I get an MRI. And you know, ultimately I will say yes or not, depending on what their symptoms and so on are, but they may have decided at that point that they're not going to stay—they're going to push for the cap, to get beyond the cap because the cap only is so much. So, whether they have genuine problems or not, they will still cause significant pressure on us.
STAMP, Q.C.:
Q. Well, I think you alluded to it actually, but I mean, essentially, aren't the medical practitioners, just like yourself, really the gatekeepers to who gets sent onto an

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MRI, an expensive diagnostic tool.
DR. MISIK:
A. You're absolutely right, I said that, we're the final arbitrator of that, but also you will see a lot of individuals that, for instance, will say, well, I don't give a damn what Dr. So and So says, I'm going to see somebody else. So, you know, and down the line they're going to pressure somebody else that may not know them, may be a little bit less reluctant in saying no, there's no necessity—they may go to the Emergency Room Department, I mean, it will put pressure on the medical health care system right now.
STAMP, Q.C.:
Q. Are you familiar, Doctor Misik, with the health levy arrangements that exist in this province, probably elsewhere too, but I just know about there.
DR. MISIK:
A. A health levy?
STAMP, Q.C.:
Q. A charge to insurance companies. Because there was a time if you were involved in a motor vehicle accident, the MCP expenses

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were kept track of and you would include that, those expenses, in the claim that was presented in connection with a motor vehicle accident. So, in addition to the pain and suffering and loss of wages and care like physio and whatever it might be, you also recovered for MCP the expenses that MCP or the health department incurred in that patient's care associated with a motor vehicle accident. That's how it used to be.
DR. MISIK:
A. So, in other words they considered the insurance company a third party and therefore that's not insured under the current system. Is that 0
STAMP, Q.C.:
Q. Well, what they did—I don't want to give a lecture—what they did was they made the lawyer, representing the Plaintiff, your patient, recover the hospital account as well.
DR. MISIK:
A. Okay.
STAMP, Q.C.:
Q. So, you became, you know, responsible to

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make sure that that hospital account got paid, but that was changed back in the mid-'90s maybe. And now there's a health levy. So, insurance companies pay a levy. The Minister of Health fixes a levy every year. He has some kind of a formula. I don't know what it is. I don't know if anybody knows what it is except maybe for the department. They assess what the cost to the, I guess, the health care system is for this kind of involvement with motor vehicle accidents and they levy insurance companies with that cost. So, whatever the costs are, the Minister figures it out, approximates it, estimates it and every year he tell them this is what you pay this year. It's a health levy. And so the kind of cost you're talking about, I'm going to suggest to you are picked up in that way already. So, if they increase, well the Minister will increase the levy. If they fall off, they Minister can, I presume, decrease the levy. But the levy is what is done. It simply replaces the direct process that existed 15, 20 years ago.

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DR. MISIK:
A. Well, I'm not familiar with that and it's not in my purview to know all these details. I do know that our patients pay for filling out forms, any of these accidents and so on, there's usually forms from the employer, from the insurance company. Right now, a lot of that is handled from the insurance company by the legal profession and I don't even get involved. But there are additional costs and these costs are from employment loss, you know, and I spend two or three hours every night filling out forms. Now, I charge for them.
STAMP, Q.C.:
Q. Sure.
DR. MISIK:
A. But that's an additional cost then to the individual that is injured or has to take time off and so on. They pay for it. I don't know who pays them for it.
STAMP, Q.C.:
Q. I'm going to suggest to you Dr. Misik that that is an out-of-pocket expense that the patient or the claimant incurs and that is

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part of what they present for their recovery, but that's not capped, not intended to be capped. That is what it is.

DR. MISIK:

A. But what I'm saying is that if a cap occurs, there's going to be more and more of these forms that I'm going to have to deal with that the legal profession was dealing with before. So, it puts the extra pressure on me. I don't want to spend an extra hour every night doing that. I got enough problems in the office. So, from my perspective that would be a fairly substantial increase cost beyond the point where I have to fill out the forms for Section B or whatever, I think there's going to be a tremendous pressure on physicians. And the bane of my existence is to fill out forms. It's just—because you never can charge your patient what it really costs in time and effort to do that, but nonetheless, it impacts me considerably.

STAMP, Q.C.:

Q. But that process, that impact, you're having it already, you're experiencing it already,

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you will continue to experience it.

DR. MISIK:

A. Yes, some of it, but there will be more, there will be more.

STAMP, Q.C.:

Q. How do you know that?

DR. MISIK:

A. Because people will come to me, those Section B forms that I was told—I didn't even know that there were additional forms that usually are done by the legal profession because I don't deal with those, but those are things that presumably I will have to fill out.

STAMP, Q.C.:

Q. And if you, and I know you don't like to do it, but if you have to fill it out, I guess you'll charge and appropriate amount and of course, that will be a part of the out-of-pocket expenses that your patient has had to pay whether it's for medicine, whether it's for over-the-counter drugs, whether it's for special shoes, I don't know what it could be, a collar, all those things that they pay for, none of that is contemplated in any of

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these circumstances to be capped in any way. None of it. So, wages—whatever the wages that are lost are, they're not intended to be capped in any way. You don't have a problem with that then, I take it.

(11:00 a.m.)

DR. MISIK:

A. No, I don't.

CHAIR:

Q. Mr. Stamp, might this be a –

STAMP, Q.C.:

Q. Yes, that's fine, Madam Chair. Thank you.

CHAIR:

Q. Back in 30 minutes.

(BREAK – 11:01 a.m.)

(RESUME – 11:31 a.m.)

CHAIR:

Q. Thank you. Mr. Stamp are you -

STAMP, Q.C.:

Q. Other than say thank you, Dr. Misik, I'm finished, Madam Chair, thank you.

CHAIR:

Q. Okay. Mr. Browne or Mr. Wadden? Mr. Browne.

BROWNE, Q.C.:

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Q. Yes, just a few questions, Doctor. It doesn't relate exactly to your own practice, but to the system generally. I've been recently involved in a Workers' Comp study, part of which in another jurisdiction, part of which emphasise the importance of early return to work for injured workers and the presenters and the experts who presented stated the earlier the person can get back to work the better it is for the worker, for the workplace, for the system entirely. Is there any directive within the medical profession generally that follows that advice? Try to get your patient back to work as soon as possible?

DR. MISIK:

A. No directive as such, but I think we're all aware of the comments you just made and there's no doubt that what you say is absolutely correct. The encouragement to get to work as quickly as possible, to deal with their issues, to do active physiotherapy treatment, not passive; to do their exercises in order to re-establish strength in their musculature and so on,

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absolutely, I agree with those comments whole heartedly. We all follow that principle, because that has been really coming from numerous studies that show that that is the key issue in getting people back to work and back to their normal activities. Absolutely, I agree with that comment.

BROWNE, Q.C.:

Q. Now, it's some of the frustrations that were presented by employers; we're dealing with the Workers' Compensation system there, but we can extrapolate. Some of the difficulties employers were having was with their own medical profession, because they did not know why the person was off; you're into privacy issues there. And they claimed the emphasis was always on the--they got a doctor's note, "off five days, off sick". The employers argue quite often that they would like to know not what the worker can't do but what the worker can do to get them back to the workplace, because often, that's a trained worker and he's missed--he or she, they're missed in the workplace. So, has that been discussed within the profession,

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to try to give more information to try to get employers to take the worker back as soon as possible?

DR. MISIK:

A. Again, I have to emphasize that I'm not currently involved in any of the associations or activities. I was chair of a number of committees for years and was involved in medical politics as well as healthcare directives for about 30 years or so. And you're absolutely right, however, we do have a form that you're familiar with, 810, and all the details that are part of this injured workers problems, whether they be that this worker has to stay off for two or three days and usually that is the case. Two or three or four days, and then to actively pursue--so, it's all there in black and white the reasons why somebody is taking off work, so I don't understand when you say that, you know, that there's nothing. We have that specific form which addresses every aspect. There's subjective symptomology, there's objective findings by the physician and then the conclusion is can

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he or she go back to their employment, can they bend, can they lift, can they twist? All these things are outlined in detail. So, and then, we always add whether this individual can go back on an ease back or some sort of modified work duties. So, that's--it's clearly outlined, so we give sufficient information to the -

BROWNE, Q.C.:

Q. Like you do here perhaps?

DR. MISIK:

A. Well, we do to the legal profession in the similar fashion. Outline exactly what the subjective symptoms were, and I do it on an ongoing basis as the visits occur and yeah, I don't see where our final reasons for taking a worker off is not there in black and white; it is.

BROWNE, Q.C.:

Q. Yeah, I think it's the early entry of that form. The number of jurisdictions are requiring functional assessment tests now right at the point the person comes for a visit. So, instead of the doctor's note they have to present the functional

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assessment note and it's becoming prevalent in the private sector, right. And the public sector, there's a lot of collective agreements and you're off and there seems to be a different culture there, but in the private sector there's a lot of frustration. So, there might be another form coming in your direction at some point.

DR. MISIK:

A. Well, I would encourage the private sector to talk with our association, because clearly, you know, while we obviously don't give away issues of privacy to any employer or whatever, we do outline that he or she can go back to work duties. So, I think that should be a simple thing to work out as it is. And Workers' Compensation, that type of form with the appropriate compensation, of course, should be easily dealt with, but that's something that I, just as an individual I respond to you. I don't really know where the association is with that.

BROWNE, Q.C.

Q. And another complicating factor that's been introduced into the system, there was

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evidence and quite often substantial evidence of the medical profession prescribing addictive painkillers, which resulted in addiction and complicated the initial injury. Are there standards in place now in this Province in reference to when certain addictive painkillers can be prescribed?

DR. MISIK:

A. Well, we all in the last few years have been encouraged and certainly our college has encouraged us to really take additional, more educational courses with respect to opioid and opioid addiction. And having done that last year, I spent three days in Toronto, the University of Toronto, they had a very detailed course on the three-day course, which you really had to write a final exam that you understood all the aspects of that. So, a lot of us are doing that and again, it's more of a private issue. We are encouraged by the college to make that happen and right now, legislation has been passed in this Province, whereby any time we have--make out a prescription

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for opioids, we have to actually check on this patient as an individual and I'm lucky I was one of the first pilot projects into the Province to do electronic medical records. So, we've been at this for two years and we can link up to any system and pharmacy throughout the Province. So, we have to now, by dictate legislation, every time somebody comes in for opioids to check whether they have been at any other pharmacy in the Province or have--we're really the gatekeepers for pharmacists, which I don't like, because we're really checking on pharmacies more than anything else. But it is a requirement by law and we all have to do that. It's a little bit of a pain again because it takes extra time and so on. Again, luckily with a computer and so on we have all the data in front--in our office at least. But yeah, that was a problem. I think that most people have dealt with that issue and you know, the simplest thing, when you know that some--and there are in every practice individuals, when you're really not sure whether you are doing the right thing

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several years ago and they have actually become addicted and then you find out too that they're double doctoring, etcetera and the simplest way to make sure these individuals take it for a good reason is to actually give them the prescription a week at a time. They actually have to see you every week, and I'll tell you very quickly, the ones that are there for the addictive part themselves are just looking for that. But now, they also have to be monitored, because you don't want them to, you know, go into a state where they just drop all their medications, but it's a good way to keep a close eye, and they actually come off their medications easily then, because they don't want to go back every week to have to get their mediation. So, we're pretty--I think the colleagues that I work with in my practice and as well colleagues that I see on educational courses of various kinds over the years, we all know that there was a problem and there still is in some jurisdictions, but we're tackling that. It's a difficult problem to deal with and I

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think we are responsible for some of that and we have to take that responsibility serious to try to turn things around and I think that's what we're doing.

BROWNE, Q.C.:

Q. Yeah, thank you, Doctor. I raised it in this forum, even though it stemmed from a Workers' Comp, because it's the same problem, right. You're dealing with I injured workers and again, it's very expensive in the system.

DR. MISIK:

A. It's the same issue and just to the point with respect to this gathering and so on, it also happens quite often in motor vehicle accident injuries, that these individuals have long-term issues and sometimes you run out of possibilities and you have to occasionally go with narcotics and we don't do that lightly, but you know, when people can't get to sleep and it affects them to the extent that their work suffers, their concentration, fatigue during the day and so on; you know, you got to worry about these individuals driving home; particularly if

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they're driving 20 or 30 minutes to get to their home. And you know, some of these guys fall asleep, so you have to be very judicious how you use those medications, but sometimes there's no other choice, but they have to go on medication that control their pain because then they can sleep, and they can function well the next day. So, it happens very often in motor vehicle accidents. So, I think your point, Workers' Compensation and motor vehicle accident injuries have a similar kind of connotation to it.

BROWNE, Q.C.:

Q. Thank you, Doctor. My colleague might have a question.

MR. WADDEN:

Q. Hi, Dr. Misik, I'm Andrew Wadden, I'm counsel for Mr. Browne, the consumer advocate and I just have a few. But I'll start by following up on the last point and sort of corroborate the last question Mr. Browne asked. Your patients who have been involved in motor vehicle accidents always tend to be prescribed, you know, some sort

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of painkiller, whether it be an opioid or something of a lesser degree. If a cap were introduced, and we've talked and thrown out all kinds of numbers, 5000, 7500, whatever it may be. Do you foresee some of your patients to find themselves in the situation where they need these drugs, they've been categorized perhaps as having a minor injury and only entitled therefore to a certain amount of money and they then cannot afford these drugs, assuming they don't have the insurance for it. I mean, you probably see that in your practice every day anyways with certain patients, but I'm just speaking strictly, specifically you rather have clients who would have been involved in motor vehicle injury?

DR. MISIK:

A. Yeah.

MR. WADDEN:

Q. Do you see something like that happening?

(11:45 a.m.)

DR. MISIK:

A. Oh, absolutely. That was part of the parcel of what I meant the increased cost.

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MR. WADDEN:

Q. Yeah.

DR. MISIK:

A. Not only to the system in terms of increased visits and so on, as well as the prescribing of medications. Some of those medications are not cheap. And then the difficulty beyond that to try to get people off is another real serious issue. But you're right, medications such as opioids, they're all very, very expensive, there's no doubt and if anybody goes beyond a certain amount that they're limited to, they continue to require those medications. It would be a burden on them given that they might have to pay it for themselves if they don't have any other insurance.

MR. WADDEN:

Q. Right. Help me understand, what is the recourse for that particular individual if they can't afford the drugs? We know they've capped in terms of compensation for an injury, we can assume that this particular individual rather doesn't have the health/medical benefits through work or

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a job and perhaps don't have accident benefits on their vehicle. That's not something they've paid for and availed of. So, they've got no avenue insurance wise to get the drugs; what generally do you patients do in that case, what happens?

DR. MISIK:

A. Well, a lot of times they're non-compliant and they end up taking only the minimum amount that really gets them basically through but continued to have ongoing symptoms. So, how--it's ironic that you bring that up, because in every field whether it's opioids, whatever you prescribe, most of the time people don't really take the medication as they should. And clearly, under those circumstances they would only take it when it's absolutely necessary and that's not a good way to keep your pain threshold at a certain level. It's really important, whatever your medications are, to take your medications so that, you know, you don't have these ups and down all day long. That's not a good way to deal with the pain. So, yeah, these

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individuals are going to be compromised, no doubt.
MR. WADDEN:
Q. Okay.
DR. MISIK:
A. And what they do, I don't know, beg, borrow and steal, I'm not sure.
MR. WADDEN:
Q. Right.
DR. MISIK:
A. And other areas of their lives would probably suffer, including some individuals' groceries or whatever else they might buy on a day-to-day basis.
MR. WADDEN:
Q. Okay. Dr. Misik, there was some discussion through some of the various questioning with respect to how many patients you have and how many you see with respect to motor vehicle injuries and things like that. I just want to get a clearer picture of that, if you don't mind. I know you can only speak in terms of your own practice. I think at one point you said you might have 50 patients a year, maybe three to four a

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month in terms of motor vehicle injuries. I'm trying to get an understanding of numbers of appointments rather than the number of patients, okay. Can you give me a rough idea in a run of a single month how many appointments rather you would have with patients in relation to motor vehicle injuries? And you don't have to just narrow it to minor stuff, whatever it is.
DR. MISIK:
A. No, no, I get you. So, this is where I come from. Our clinic has been in existence since 1970. We have approximately 70,000 file charts. Now, obviously they're not all active, but those are individuals that have registered in our clinic over the years. And a lot of these individuals keep coming back, of course on a regular basis, so they're active patients.
MR. WADDEN:
Q. Sure.
DR. MISIK:
A. I can tell you that on average I will see about 200 patients a week. I will certainly--and some of my colleagues as

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well. I mean, I've been there the longest, so my practice is more mature, if I put it that way. So, these individuals have--in the Winter I can often see five or six a month and I don't take appointments. So, appointments are not in my vocabulary, I take mostly walk-ins and people often wait three and four hours and you know, that's their choice. The reason why I do that is if I have appointments I get stressed, I don't want to end up with a heart attack. So, I feel that if somebody wants to see me, it's up to them if they want to wait. I don't know what any person might come in with, I have no idea, but I know that starting November right through April it's a lot, there will probably be more than four or five individuals. I can't give you an exact number, but I would guess 40 to 50 a year sounds reasonable. During the summer, I will write three and four letters per month, every month to the legal profession on behalf of my patients and clients and that's how I operate. But those are rough numbers just from memory.

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MR. WADDEN:
Q. Thank you, and I'm sorry, I don't want to belabour this, but I do just want to maybe ask that again, just to get a little more clarity. So, if you're saying five to six patients a month that doesn't necessarily translate into five or six appointments in that month? That could be five or six patients that you've seen through ten appointments, right, because some people come back a couple of times, that type of thing?
DR. MISIK:
A. Yeah, absolutely correct.
MR. WADDEN:
Q. Okay.
DR. MISIK:
A. Most of the time you see somebody within two or three days when they come in after an accident or they've been advised by police or whoever at the accident scene to see their physician, you know, the next day or whatever, if they don't end up with an ambulance, which happens quite often too. So, yes, a lot of these individuals I will

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see sometimes, depending on the objective findings, will see – ask to see them in the following week or two weeks later. So, I will see them two or three times a month for sure.

MR. WADDEN:

Q. Okay. And let me come at it – so, I get what you're saying. Let me come at it a different way because I want to have sort of a different analysis here. I mean, you said – at one point you said, I guess, since starting practice you've had 70,000 files, right?

DR. MISIK:

A. Well, that's not my own personal. That's our group. So, that – that's the number we have gotten to. Now, we've stopped doing that because for two years, we're all electronic, so we don't have any paper files any more. So, 70,000 is where we sort of stopped at that point having paper files. So, it's all electronic now.

MR. WADDEN:

Q. All right. Dr. Misik, are you able to give me an idea how many active patient files you

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have right now? How many people here in town, in Newfoundland rather, would say "Dr. Misik is my doctor"? How many do you have?

DR. MISIK:

A. I don't count. I have no idea.

MR. WADDEN:

Q. Okay.

DR. MISIK:

A. But, no idea, I can tell you Mondays and Wednesdays, I will see 45 to 50 patients. I work half days on Tuesday and Thursday and I will see 25 to 30 patients in that time, because everybody wants to be packed in on Thursday. During the summer, I don't work on Fridays, but I will in the winter. Take four or five appointments in the morning, just to get some of the backlog out of the way and then we have, in the winter, a Saturday morning clinic where one of us is present and often see up to 50 patients on Saturday morning, and those are usually individuals with minor viral infections and so on, and you know, thrown in there, people could arrive having had an MVA a few days ago and then you have to take a bit more

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time to get the initial thing or get them back two or three days later, if it's not that acute at the time, to reassess and objectively get something down on paper in order to make sure we follow things appropriately.

MR. WADDEN:

Q. Okay.

DR. MISIK:

A. So, I'm not sure if that answers what you were looking for, but that's the best answer I can give you.

MR. WADDEN:

Q. Okay. It didn't – and I get where you're coming from in telling me – and given the number of patients you have, I can see it might be tough to answer some of these questions because keeping track of it all must be – you must have a few staff, right.

DR. MISIK:

A. I don't keep count and I'm not about to. I just see people as they come.

MR. WADDEN:

Q. Okay. We've used numbers like 50 patients a year in terms of MVA victims. Here's what

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I'd like to know, if you can answer this for me. How many active patients, I'll say active clients, active consumers of medical care do you have right now who are seeing you because of MVA related issues?

DR. MISIK:

A. Well, I would venture to guess – if you're talking 40 to 50 through new cases?

MR. WADDEN:

Q. Right.

DR. MISIK:

A. I would at the same time always have about 40 to 50 people with ongoing problems.

MR. WADDEN:

Q. Okay.

DR. MISIK:

A. That have been seen in the prior year or six months ago or two years ago or whatever.

MR. WADDEN:

Q. Yeah, I get you. So, on a consistent basis, you got 50 individuals who you're seeing for MVA problems on any given week, month, year?

DR. MISIK:

A. Yeah, about that.

MR. WADDEN:

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Q. Right, okay.
DR. MISIK:
A. And I don't want to -
MR. WADDEN:
Q. I'm not going to nail you down to that number. I get it.
DR. MISIK:
A. No, no, but I have a big practice.
MR. WADDEN:
Q. Sure.
DR. MISIK:
A. And these individuals, almost on a daily basis, I will see somebody that has some related issue to a motor vehicle accident.
MR. WADDEN:
Q. Okay. Now, you've seen – and it was in your letter, you know, various definitions with respect to minor injuries that exist in other provinces. If a cap comes in in Newfoundland, presumably there will be a definition in relation to that cap in terms of injuries. Who knows how that will look? Of these – of the, you know, given 50 patients you're seeing at any given time for MVA injuries, how many of those people do

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you think would be impacted by a minor injury definition or cap? Some might fall outside of it. Do you have any idea?
DR. MISIK:
A. No.
MR. WADDEN:
Q. Okay.
DR. MISIK:
A. And because, as I said before and I will consistently say, those definitions, in my mind, are not worth the paper they're written on. I think there's so many individuals, whatever the definition might be, that would fall outside of that definition that I even would not be able to venture a guess how many that would comprise of. So, I don't like the definition. I don't like any of those definitions. I don't think in this day and age and going forward, the way medical practice is going, it does not make any sense to me.
MR. WADDEN:
Q. Okay. I'll move on from that now. One of the things that I think Mr. Templeton was asking you about this, and it's in the

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letter that you wrote at point two, and we don't necessarily need to bring it up, or it is already up actually, so that's fine. In reference to a minor injury cap, you indicate, sort of halfway down through point two, "this will no doubt lead to substantial increases in requests for medical and medical therapy appointments, more diagnostic requests, et cetera" and you go on there. And you've been asked why you think that is and I get what you're saying.

There's been some suggestion, you know, sort of throughout these hearings and in one of the documents we looked at at one point, I can't recall right now, that a minor injury cap can possibly reduce the amount of people that report a claim to their doctor or attempt to avail of compensation in the first place. Now whether that's right or wrong, I'm not sure, but it is a theory that's been put out there. Is it your view that that is not the case? Because what you seem to be saying is this is going to put more of a burden on the system. I would think if it's the case that a minor injury

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cap was going to reduce the amount of people that report claims to their doctors, it might lessen the burden on the system. Do you have any comments on that?
DR. MISIK:
A. Yeah. I know currently there are a number of patients that fall outside of my 40 or 50, and I don't know exactly what that number is, but quite a few end up having no complaints whatsoever and feel fine a week or two later, and I don't even – I don't see those individuals.
MR. WADDEN:
Q. Right.
DR. MISIK:
A. They don't come in. They don't have any problems. There may be ones that, you know, have a compensation of three or four thousand dollars because they lost a couple of days work, but they're fine. So, I don't see those individuals. The individuals that I see most of the time will go on six months or longer and I feel that if there was a cap that were to be introduced, they will actually pressure us more to – and it's

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difficult sometimes to objectively assess an individual with respect to back issues, whether their upper neck or lower back. You have to have a fair bit of experience to be able to tell whether somebody's really pushing you to try to get further compensation or whatever. But what I think is if there's a cap, it might actually drive these persons to try to seek to get beyond the cap and I think that will be a greater pressure on physicians because often with – even without any – with no objective evidence that there is serious problems, you sometimes have to give the patient the benefit of the doubt. I trust – if you don't trust your patient – you have to trust your patients what they tell you, and I know from experience, very, very frequently, people know themselves what's going on and they will tell you and even if you don't find things objectively at that time, sooner or later, it'll come out. I always trust what my patients tell me. I will follow that up with some objective determination,

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but I do believe that there will be extra pressure put on the medical profession and the system as a whole if that cap is introduced because the people that come to me already have problems that I think will probably fit beyond whatever the definition is going to be.

(12:00 noon)

MR. WADDEN:

Q. Okay.

DR. MISIK:

A. It's really not an exact science.

MR. WADDEN:

Q. Sure.

DR. MISIK:

A. And so medicine is based on both science and the art of medicine and if you can't deal with both, it's very difficult to be a physician that cares for their individual patients. It takes the art of medicine to persuade somebody that really they either do not require a C-spine x-ray, but the insurance agency always demands a C-spine x-ray because if they don't see anything on x-ray, they believe that this individual has

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no problem, and that's totally wrong. But you don't need an x-ray. You can make a determination of soft tissue injuries very easily by objectively assessing that patient. So, the pressure will be on us to really see whether we can trust our patients, which I do, if they continue to have complaints, even though objectively I may not find anything, but I often give people the benefit of the doubt because I know – I know some of these individuals for years and years and years. So, I know what they're telling me is correct. That despite everything, they can't sleep at night. They're tossing and turning. They feel uncomfortable. And prior to the accident, they didn't have any of those problems. And yet you see them and you don't often find a hell of a lot, but nevertheless, they tell you that and I trust that they're telling the truth.

MR. WADDEN:

Q. Okay. That's a good point. I'm going to come back to that in a second. I just want to follow up on my last question in terms of

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your view -

DR. MISIK:

A. I'm sorry, I sort of lost the gist of your question in the process.

MR. WADDEN:

Q. No, no, that's good. The more information you can give everybody in this room and the panel, the better off we all are. I just want to go back to my earlier point about your views as to burdens on the system and perhaps the necessity of patients to make more requests and have more appointments, things like that. You've been at this a long time. I suspect you have colleagues outside of the province of Newfoundland. And the benefit of this forum is that we can listen to anecdotal evidence and give what weight to it we wish. Like do you have colleagues in Nova Scotia, New Brunswick, any of the other Atlantic Provinces who you've spoken to on these issues and if so, can you give me some idea of their experiences there and what they might say or what their views on all this is?

DR. MISIK:

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A. I do have colleagues all over the country because I was doing a lot of research for 20 years. So, I had to travel a lot to research meetings and so on. So, I've developed quite a network. Unfortunately, a lot of these colleagues are retired, which is not in my vocabulary. So, I currently don't have any great deal of dialogue with any of those individuals. I gave up doing research in 2005 simply because we have a Board in this province that is inept and they do not like private practice in research. So, they stymied a lot of the research projects that were ongoing and that's why I gave up in 1995, and currently, as a lot of people know, Sequence Bio is a phenomenal company, private company in this province, and they've had substantial issues and so on. But yes, to your point, I do have a lot of colleagues and had a lot of colleagues, but as I said, I don't have any great dialogue and haven't had for the last five or six years, on this issue or anything else.

MR. WADDEN:

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Q. Right, okay. I understand. Let's go back now to what you said about, you know, your ability to deal with patients and sort of assess objectively what they're telling you is, you know, true or false. I think the turn of phrase you used earlier was, you know, you know when somebody's pulling the wool over your eyes, right. Pretty much all the lawyers in the room have over the years seen reports from physicians and we've all seen independent medical examinations and oftentimes these reports refer to whether or not the individual being assessed is exaggerating their symptoms, you know, things of that nature. How do you – when you're doing that, how do you make that assessment? And outside of that, do you see that very often? Do you find it to be the case that individuals who come to you for injuries related to MVA are exaggerating their symptoms or not? What's your experience?

DR. MISIK:

A. Oh, the vast majority absolutely do not. But, how do you determine that? I can tell you that the best way you can tell that is gut, my gut and my nose. My father told me in order to be a good physician, you got to have a good nose, and I don't mean necessarily the smell, but to figure out whether somebody is telling you stuff that really does not make sense or not. So, it's just experience and often simple things like watching a person walk out the door or watching them get in their car after being seen tells me an awful lot. So, having a good nose and having a sense of understanding that there is part of medicine that requires the art of medicine and not necessarily science.

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MR. WADDEN:

Q. Okay. When you know you know?

DR. MISIK:

A. Well, if you don't know after 48 years, I'll be in big trouble.

MR. WADDEN:

Q. Fair enough. You know, there's been some questions asked – I may have even asked you one just now about, you know, sort of level of injuries you see from different patients,

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and I'm sure the injuries you see with respect to your patients involved in motor vehicle accidents sort of run the gamut from – I won't use the word "minor" – from one end of the spectrum to the other.

DR. MISIK:

A. Right.

MR. WADDEN:

Q. But are there, you know, in your experience in all these years you've had of dealing with patients, clients rather, who have motor vehicle injuries, are there some who can be categorized as what I'll call the low end of the spectrum, what some people will call minor? In other words, six months, they're good. There's no reoccurrence. Because I know you've said, and I understand it, we all do in the room, that sometimes people feel pretty good after a few months, but then things sort of come back, whether or not there's a second accident or not, four or five months down the road for whatever reason. But do you ever – you know, have you often seen it to be the case that after six months, they're good and

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there's no revisiting?
DR. MISIK:
A. Absolutely. Absolutely.
MR. WADDEN:
Q. That's does happen?
DR. MISIK:
A. Absolutely, and it's – it happens all the time. A lot of people do recover substantially, both from a physical and a mental health issue. I mean, some of these individuals don't have any problems in dealing with some of those issues because genetically they are different than the next person who may have had a more minor kind of impact in their accident and yet sometimes you see it go on for years and continue. I know of one individual, I mean, right now that comes to mind. She was just in a few days ago. She had an accident 14 years ago. Whatever happened with her settlement and so on, I don't really know and I don't really care, but she continues to have significant muscular problems that the only way you can really detect is by previous diagnosis of fibromyalgia with 18 trigger points and so

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on, and she has all of them. I mean, and there is no question about that. So, she has developed – and a lot of people do – from a traumatic incident, they never had an accident before, they've been driving for years, they're elderly and all of a sudden, boom, and not their fault because they're medically fit to drive and so on, but somebody bumps into them. And these individuals are traumatized for quite a period of time.

But yes, there are others that seem to be perfectly all right after four or five months and I usually tell them to wait for another three to four months and just see them one last time before I decide yeah, that seems to be fair. They don't have any issues. So, I think what you're describing really is exactly what I'm talking about. There is a spectrum.

MR. WADDEN:
Q. Yeah.
DR. MISIK:
A. But it's an individualized spectrum, okay.

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It's not one that you can globally define that somebody fits into this category or that. It really is individual because everybody reacts differently to the same accident.
MR. WADDEN:
Q. Okay. I just want to ask you briefly about your experiences in dealing with patients who are availing of their accident benefits, known as Section B. So, you know, probably not telling you anything you don't know. There's been some discussion already here today of Section B, but basically it's coverage you have on your own vehicle to help pay for things like physio treatments, little bit of loss of income, things like that.
DR. MISIK:
A. Um-hm.
MR. WADDEN:
Q. Okay. It's elective. Some people have it; some people don't have it. If you have a patient involved in MVA and you refer them for, you know, active treatment, physio or chiropractic treatment or what have you, and

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their method of paying for that is going to be their accident benefits insurance, do you often or have you ever found it to be a problem that the insurer may not cover things or challenging coverage for the patient? Does the patient then have to return to you for a second letter, things like that? I just want to get your experiences in that.
DR. MISIK:
A. Well, quite often that is exactly what happens. They've exhausted their -- whatever money they get from -- whether it's 500 for this, and I have to say "look, I can't deal with this issue. You do need to see a psychologist. You're obviously traumatized and depressed and so on and you have to see somebody to help you through that" and I just refer them back to their legal counsel and say "look, let them handle it. I don't handle that part". I just know that they need further treatment. It's been denied to them. Let their lawyer handle that because that's not my role.
MR. WADDEN:

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Q. Okay.
DR. MISIK:
A. And that's what I currently do and it happens quite often.
MR. WADDEN:
Q. There was some talk – this is the last thing I just wanted to discuss. There's been some discussion about costs of, you know, the medical reports, letters, things like that, and how – and it seems you have a good understanding of the fact that that cost ultimately does get passed – in the case of a personal injury action, it oftentimes gets passed on to the client, i.e. your patient, right. So, what – like in your practice, your chart, if you're writing a report – okay, a lawyer writes you and says "Dr. Misik, I need a report on this particular patient", number of questions in there. Say it's going to take you three to five hours to write it. I'm sure you do a number of those a month. I think you gave a number, maybe three to five a month, right. Are your charges then for that report, do they go in line with the NLMA guidelines? What's

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the cost of – what do you charge per hour for a report?
(12:15 p.m.)
DR. MISIK:
A. Just to back up a little.
MR. WADDEN:
Q. Sure.
DR. MISIK:
A. If I do receive a request for that, I usually review the file fairly quickly to get an understanding of what the timeframe will roughly take, and sometimes I'm under, sometimes a little bit over, but I estimate say that it's a three hour thing.
MR. WADDEN:
Q. Sure.
DR. MISIK:
A. And you have to understand that really I cannot do this during office hours. All these reports are done on the weekend. So, it does interfere with my weekend activities. So, almost all of them – I got two letters to do this weekend. Our fee schedule, Newfoundland and Labrador fee schedule says $450 an hour, and that's what

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I charge.
MR. WADDEN:
Q. Okay.
DR. MISIK:
A. And I always, always ask that that be paid in advance. And the reason for that is that I was dinged several times over the years, having – and this is not in recent years, that goes back a long time; that I would do the letter, have everything ready, and then I get a call from the lawyer saying "I don't need the letter now". So, I – and this has happened in the past several times. So, my commitment that I have on my invoice is to give an estimation. As soon as I receive the money, I will have a letter to the lawyer within 20 working days, and that's my policy and I follow that to the letter. If I cannot do that because I'm on holidays or away, I actually send a letter or my secretary telephones the lawyer and lets them know that there is going to be a timeframe where I'm going to be away, so that 20 days has to be extended. And I stay true to that. So, actually a lawyer does

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have that letter in great detail at the end of – but it does take time to put it all together because you got to review every single detail. And I write a fair bit on my notes for every visit that this patient is there for.
MR. WADDEN:
Q. Okay.
DR. MISIK:
A. And by the way, I've never been denied that prepayment. Everybody does it because they know they will receive a report that corresponds to the timeframe that it took within 20 working days.
MR. WADDEN:
Q. Okay. Thank you, Dr. Misik.
CHAIR:
Q. Thank you, Mr. Wadden. Mr. O'Flaherty?
O'FLAHERTY, Q.C.:
Q. No questions.
CHAIR:
Q. Mr. Feltham, do you have any questions you wanted to ask on -
MR. FELTHAM:
Q. No, Chair. Thank you.

COMMISSIONER NEWMAN:
Q. No questions.
COMMISSIONER OXFORD:
Q. No questions.
CHAIR:
Q. And I don't have any questions either, Dr. Misik. Thank you very much.
DR. MISIK:
A. You're welcome. Thank you.
MS. GLYNN:
Q. We are back on Monday. We have four different panels presentation scheduled for Monday and Tuesday. I understand that the Campaign will circulate an email later today to advise of the order of those presentations.
CHAIR:
Q. That'll be helpful. Thank you very much. Enjoy your weekend everyone. We'll see you on Monday.
UPON CONCLUSION AT 12:20 P.M.

CERTIFICATE

I, Judy Moss, hereby certify that the foregoing is a true and correct transcript in the matter of the 2017 Automobile Insurance Review heard before the Board of Commissioners of Public Utilities, 120 Torbay Road, St. John's, Newfoundland and Labrador and was transcribed by me to the best of my ability by means of a sound apparatus.

Dated at St. John's, Newfoundland and Labrador this 7th day of September, 2018

Judy Moss

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