Loss of competitive advantage is not identical to loss of earning capacity

By Thelson Desamour
assisted by Suzanne White

When drafting a claim for a personal injury plaintiff, it is often difficult to assess whether to pursue a claim for loss of competitive advantage. Loss of competitive advantage is a speculative head of damage, which is difficult to quantify. Similar to loss of earning capacity, loss of competitive advantage is awarded for the impact of an injury on a plaintiff's employment. Because of the similarity, in some decisions, both awards have been used interchangeably, however, they are not the same.

Generally, loss of earning capacity is awarded for "catastrophic" or serious injuries where the plaintiff is no longer employable. Loss of competitive advantage on the other hand is awarded to plaintiffs who are able to work, but are facing employers who will pass them over for fear that the candidate is more likely to suffer a subsequent injury, (potentially affecting the employer's worker's compensation premium) or facing employers who will pass them over because the candidate is deemed to be less productive than a non-injured candidate. Both loss of competitive advantage and loss of earning capacity can be pleaded, however, the decision to award only loss of competitive advantage in *O'Day v. Facoetti Estate*, [2002] O.J. No. 2374 (Sup. C.J.), demonstrates that there is a distinction between the two types of damage awards.

There are two underlying reasons for awarding a loss of competitive advantage award: (1) the plaintiff is being compensated for the pain and suffering he or she endures while working as a result of the injuries, e.g. fatigue and absence from work due to the injury; and (2) the plaintiff is being compensated for the lack of competitiveness or disadvantage he or she *will* face in the workforce in comparison with a non-injured worker.

The test in Ontario for determining whether there is a viable claim for a loss of competitive advantage damage award is found in *Longeuay v. Thomas* (1982), 35 O.R. (2d) 660 (C.A.). The appeal court affirmed the trial judge's method of assessing the claim based on a two-part test. Part 1 asks whether there is a substantial risk that the plaintiff would lose his or her present job prior to the estimated end of his or her working life. Part 2 states that if there is (but not otherwise) a substantial risk, the court must assess and quantify the value of this damage.

As this head of damage is largely speculative, quantum as identified by the courts falls along a broad range. How does one quantify the appropriate amount to

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compensate an individual for pain and suffering on the job, prospective discrimination in the work place or the inability for the employee to be promoted, because of their injuries? The difficulty in assessing damages for loss of

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Booster seats are an important next step in protecting children

By Michael Shannon

Every day millions of children in North America are being put at risk of catastrophic injury or death because they are being put into safety equipment that was never designed to fit them in the first place. They are referred to as "the forgotten children" — those children who are too large for child car seats, yet too small to be properly protected by seatbelts.

Despite the fact that in 1976 Ontario was the first jurisdiction in North America to make wearing seatbelts mandatory, for many years children from four to nine years of age were ignored by the Ontario government. Usually, these children were moved from their car seats and either placed in the rear seat with an adult seatbelt or not belted at all. People did not appreciate that an unrestrained child in a 50 km/hour crash would suffer the same consequences as a child dropped from a third-storey window!

Recently I have acted for a number of children, ages four to seven, all of whom were rendered paraplegics as a result of not being seated in a booster seat. All of these catastrophic injuries could have been prevented if the children had been secured in booster seats, rather than being restrained with adult seatbelts. The studies indicate that booster seats can provide 60 per cent more protection than seat belts alone.

Parents assume that they are being responsible by taking their four-to-nine-year-old children out of car seats and putting them into a regular seat and only restraining the child by the seat belt. Parents and guardians are unaware that seatbelts are designed so that the pelvis withstands the force of a crash, the pelvis of a 165-pound adult male! Not the pelvis of a child. A child's pelvis is too small. Notwithstanding the overwhelming data that proves that car crashes are the no. 1 cause of death and serious injury for Canadian children, parents have failed to hear and respond to the government's message.

Finally in September 2005, the Ontario government passed a law to "Enhance the Safety of Children and Youth on Ontario's Roads". This law clarifies the responsibility of driver's when travelling with preschoolers and primary-grade-age children to buckle up in an appropriate child car seat, including booster seats. It is now the law that a child must be in a booster seat if they are under the age of eight, weigh 18 kg or more but less than 36 kg (40-80 lbs.) or are shorter than a standing height of 145 cm (4 feet 9 inches). Failure to use a booster seat can result in two demerit points and a fine of $110. More importantly it could result in the loss or serious injury

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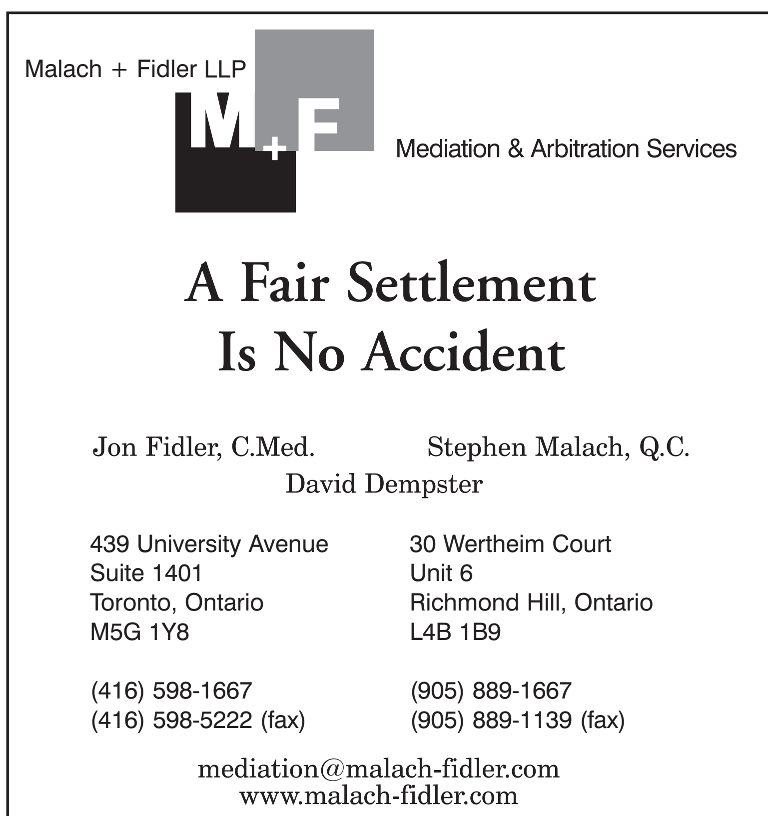
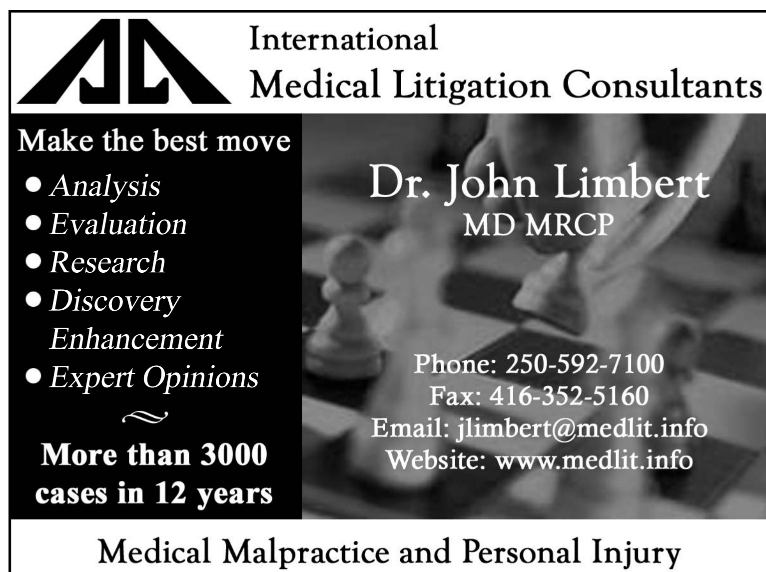
to your most "valued possession".

Booster seats are the vital next step in protecting children who have outgrown their child seat, but are still too small for a seatbelt. Booster seats allow a child to safely use an adult seat belt. The booster seat raises the child so that the belt is positioned properly over his or her body. Until nine or 10 years of age the child's pelvis is underdeveloped, making it difficult to maintain correct lap belt positioning over the upper thighs. If a child's thighs are shorter than the vehicle seat, this will result in the child slouching and causing the seatbelt to ride up over the abdomen. If this occurs, it could cause a child to "submarine" upon impact, further resulting in the lap portion of the seatbelt to rise higher on the abdomen and risking serious internal injuries and/or spinal cord damage.

The Ontario legislation, in my opinion, is only a minimum standard. Parents should go further than these minimum standards to ensure the protection of their child. A child should be restrained in a booster seat until a child is nine years of age, can sit with his or her back straight against the vehicle seat and have their knees bend comfortably at the edge of the seat and have a seating height of not less than 74 cm (29 in.) and weigh at least 36 kg. By doing this, it will substantially reduce the risk that a child will be catastrophically injured in a motor vehicle accident and the guilt of a parent who realizes that their child's injury was preventable.

Michael Shannon is a past managing partner of Cassels Brock and Blackwell LLP and practises exclusively in the area of personal injury litigation on behalf of plaintiffs, focusing on serious injury cases and medical malpractice.





Misdiagnosis is often a sign of negligence

By Dr John Limbert

Faulty diagnosis is the most common type of medical error occurring in emergency departments, in the practice of internal medicine and in some medical subspecialties. Similarly, medical malpractice actions that result in settlement are most commonly based on misdiagnosis.

Moreover, diagnostic errors are more likely than other types of medical mistake to arise from substandard care.

With monotonous regularity, a small proportion of myocardial infarctions are misdiagnosed in the emergency departments of Canadian hospitals because well-established routines for analysis of chest pain are not completed.

Among women reporting a breast lump to their general practitioners, those under 40 are at greater risk of having a cancer missed because one or more of the three standard tests are omitted — clinical re-examination, appropriate diagnostic imaging and biopsy.

Diagnostic process

Two cognitive processes are combined: heuristics and hypothetical reasoning.

Heuristics are “rules of thumb” or pattern-matching. They are time-savers but potentially fallible.

“When you hear galloping hooves, think horses not zebras” works well most of the time, but during a “flu” epidemic this approximate aphorism is particularly dangerous for the patient with early meningitis.

As soon as a consultation begins, the physician also starts generating hypotheses, based on a combination of book knowledge and clinical experience.

Applying deductive reasoning to the hypotheses is fast and automatic. Indeed, when selection among the two to six most likely diagnoses is more rapid, diagnostic accuracy tends, if anything, to be greater, not lesser.

However, the diagnostic process also requires a search for evidence to confirm or refute a provisional diagnosis. This component is controlled, deliberate and frequently time-consuming.

Sources of error

Not all diagnostic errors are avoidable in our present state of knowledge. The majority of instances of a given medical condition do not present to the physician as textbooks describe. Some occurrences of a disease are so masked or atypical that what looks initially much more like a cat turns out subsequently to be dog .

It is not rare for patients to fail to give an adequate account of symptoms, to be unable or unwilling to cooperate, or even intentionally to deceive.

Experienced emergency room physicians learn to be particularly cautious of misdiagnosing patients who are psychiatrically ill, impaired by drugs or alcohol, aggressively hostile or head-injured.

Contributing to avoidable mistakes are either system-related deficiencies or cognitive errors — and usually both. In a study of diagnostic errors in internal medicine, system-related errors were present in about two-thirds and cognitive errors in about three-quarters of the cases.

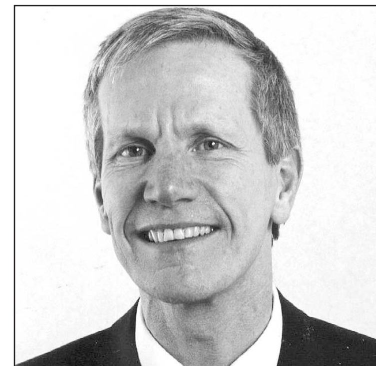
System-related factors that lead to diagnostic error include technical failures, equipment problems and organisational flaws.

The aviation industry categorises cognitive errors as arising from 1) data collection 2) interpretation or 3) planning.

It is rare for medical diagnostic error to be caused by lack of knowledge and uncommon for misinformation to be the main factor. Most common is the physician’s faulty synthesis of the facts.

Researchers into misdiagnosis have identified a number of common cognitive errors. Most frequently seen in medical malpractice litigation is premature closure. For a variety of organisational and interpersonal reasons, the physician fails to check out his initial hypothesis with sufficient thoroughness — by fuller medical history, physical examination and standard laboratory tests or diagnostic imaging studies.

When fresh and alert, a reasonably conscientious physician will make a vigorous effort to disprove his working diagnosis. The same clinician may, when exhausted or sleep-deprived, over-trust his initial pattern-matching. Preliminary research suggests that this readiness to accept initial hypothesis without sufficiently rigorous scepticism is not less but more common among more experienced and senior physicians, even when they are otherwise functioning well.



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If meningitis is suspected, spinal tap is mandatory. This procedure can be distressing for a child, time-consuming for the physician. A dangerous strategy is to repeat the physical examination in the hope that the signs will this time be less convincing.

Medico-legal implications

Although diagnostic errors are often unavoidable, medical malpractice clients are more likely to have a viable claim if the potential cause of action is misdiagnosis or delayed diagnosis.

When diagnosis is mistaken,

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Speculation in determination

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competitive advantage is not assisted by other questions such as, whether the court should consider the effect of the plaintiff’s injury on her present employment or against all employment? The court in *Leszczynski v. Clark* (1993), 17 O.R. (3d) 451 (Gen. Div.), aff’d (1997), 34 O.R. (3d) 805 (C.A.), considered the question above. The trial judge concluded that as the plaintiff was a marginal worker, an injury to his back had a greater impact on him than on an individual who was a semi-skilled or even a skilled labourer. The trial judge held that “the plaintiff’s choice of jobs was more limited and in all likelihood he would be confined to work at minimum wage levels”. In addition, the court found that “the plaintiff would require more time from work as a result of flare ups and pain and as a result of his flare ups and pain, his employment would be transient and he would have less opportunity for promotion.” In many cases with and without the assistance of actuaries, the courts have simply made a finding and awarded a sum. There are also decisions such as *Wilson v. Kee*, [1998] O.J. No. 6243 (Gen. Div.), where the plaintiff was not being discriminated against in the workplace and her post-accident income was higher than her pre-accident income, but despite those facts, was able to make a successful claim for loss of competitive advantage.

When advancing a claim for loss of competitive advantage, it is helpful to obtain a vocational assessment and functional abilities evaluation prior to trial. If accepted by the court, these reports can carry critical weight in the assessment of damages. In the recent decision of *Bernier v. Assan*, [2006] O.J. No. 1978 (Sup. C.J.), the plaintiff raised the issue of loss of competitive advantage and loss of earning capacity, but did conduct a functional abilities evaluation. The court held that such a test was material to the claim and ordered that the plaintiff submit to evaluation.

Loss of competitive advantage certainly isn’t simple because determining quantum is speculative, however, the speculative nature of the award can also be advantageous. Despite the fact that this type of damage award might be viewed as a grey area, with the right client, facts and expert assistance, loss of competitive advantage is a claim worth pursuing.

Thelson Desamour practises in the areas of civil litigation and mediation, including in personal injury and employment law, at Carters Professional Corporation.

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