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Ontario Auto Insurance Three-Year Review:

Putting the Quality and Integrity Back Into Our Insurance System in Ontario

March 31, 2014

Introduction

FAIR Association of Victims for Accident Insurance Reform is a volunteer, not-for-profit consumer organization whose membership is comprised of motor vehicle accident victims and their supporters.

We advocate for fair treatment for all of Ontario's accident victims.

FAIR operates an information based website that has over 1400 visitors each month and we post accident survivor stories and relevant media on our website. We post information about the claims process, IME assessors and the various issues that our members bring forward on an open access website. FAIR and many of our members have made appearances at Queen's Park to the Standing Committees and Budget Committees and at various stakeholder meetings and consultations with respect to auto insurance policy.

We welcome the opportunity to provide input on the mandatory 3 Year Review of Ontario Auto Insurance by the Financial Services Commission of Ontario.

We are the end users of the insurance product and we hope that our concerns, which potentially affect the nine million drivers in Ontario, will finally be addressed with this review process.

Accident victims' central concerns are about the way they are treated through the claims handling practices of Ontario's insurers when making a claim for benefits following an MVA and their access to medical rehabilitation and benefits.

Many of these concerns can be addressed by following the FSCO stated mandate: **"To provide regulatory services that protect the public interest and enhance public confidence in the regulated sectors."**

The FSCO failure to follow this simple mandate to provide adequate regulation and ensure adequate oversight, despite both the obligation and the obvious need to do so, has eroded public confidence in Ontario's insurance scheme.

Accident victims know far too well that the present system works for some but not fairly for all MVA survivors. The arbitration backlog of claimants who have not been able to access the benefits promised in their policies and the uncertain environment created by constant changes to legislation is evidence that our insurance system is broken and no longer works for Ontarians.

Access to Treatment and Benefits

When the legislation is changed to accommodate the insurance industry demands to decrease benefits, there is an increase in claims filed down the road. The changes to coverage, new thresholds, the Minor Injury Guideline (MIG), the Anti-Fraud Task Committee recommendations and the constant narrowing of eligibility since 2010 has created a war on Ontario's legitimate accident victims.

According to the DRS Interim Report, 45% of the claims working their way through the FSCO mediation system are for medical treatments. This is truly disturbing when one considers the personal cost to those thousands of individuals who are not getting the treatment or care they need for recovery.

Ontario's insurers have been calling their customers opportunists and fraudsters for years and using their preferred vendors of medical opinions to deflate claims and delay payouts, while the truth is that the majority of benefits in dispute are those that will promote wellness and recovery. Rehabilitation has no opportunistic dollar value to a claimant. The value is in the recovery to an injured accident victim and yet accident victims are often accused by Ontario's insurers of trying to 'enrich' themselves.

The volume of denied benefits in 2013 alone is astounding. We see the 25,329 injured accident victims who had applied for mediation based on benefits denied by their insurer as a major crisis. Many of the treatments for trauma are not available in our public health system and the MVA victim is simply abandoned and ultimately loses the window of opportunity for timely treatment. This is counterproductive to society and the cuts to benefits, the delay and the denials, are standing in the way of an accident victims ability to return to as normal a life as possible. Coverage and security is the very intent of having insurance coverage.

The fact that 45% of those cases have been brought into dispute because an injured person has been denied medical benefits means that in this past year alone (2013), 11,399 people waiting for mediation are without timely or appropriate medical treatment to aid in their recovery. Somehow these innocent accident victims have become victims of poor policies and to the war on fraud and had their claims denied.

The DRS internal database figures suggest that at least another 5,000 people of the current 10,752 cases pending at the Arbitration level are more MVA victims that are also without adequate treatment. This tells us that since December 2012, there are potentially over 16,000 people in Ontario who are unable to get the treatments and medical supports they need to recover from a car accident. An additional 25,521 injured accident victims have accessed the Superior Court of Justice because they too remain without adequate coverage of their expenses and treatments. This is unacceptable. This is not adequate coverage or an example of a system that is working.

It isn't enough to get rid of the Mediation backlog merely to have Arbitration hearings increase - it isn't a solution for what ails the insurance system which is the bottleneck of unsatisfied and injured consumers waiting for justice and who have been denied what they paid for. These are people who, through no fault of their own, are impoverished by the system the government has endorsed. People whose treatments are delayed, the road to recovery full of obstacles and thresholds, in a system so complicated and adversarial that it requires legal representation to navigate through.

Independent or Insurer Medical Examinations IME/IE

The backlog in the courts has these biased and shoddy medico-legal reports at its root - insurers are caught in their own policy of accepting these biased reports that later don't pass muster in the arbitration hearings and thus have to pay interest to the poor accident victim whose life has been

trashed while waiting years to get to a hearing. Insurers who properly and competently handle claims don't have to pay the high amounts of pre-judgement interest payments - just those same old insurance companies whose names are so often on the arbitration hearings docket and who regularly call their legitimate claimants malingerers have to pay. Reducing the interest rate would be like an incentive to abuse victims and deny and delay claims for some of Ontario's insurers who stand to make higher profits with the lower interest rates.

Why can we not fix the system?

To fix the problems that Ontario faces with poor coverage and the high volume of litigation, the FSCO must stand behind their mandate and do what needs to be done, enforce regulations so that the independence and quality is put back into the process of medico-legal examinations and reports. Higher standards must be in place at hearings in respect to the expert testimony that the system relies on to decide entitlement to benefits.

FAIR has suggested that oversight with a Colorado – style or roster of qualified assessors be put in place to protect vulnerable accident victims and that the qualification and supervision of those assessors be under the government's oversight. FSCO already has the means to recover the costs of such a roster of qualified assessors from Ontario's insurers. There is no real or valid reason to not protect some of the most vulnerable citizens in the province by providing such oversight when clearly the insurance industry and the regulatory colleges have failed in their duty to protect the public.

The medical evidence, used to decide whether a claimant is entitled to coverage, should be of the highest standards and those who provide these reports should be held to account for the work they do. Sadly, injured MVA victims are forced to deal a Wild West version of medical diagnoses churned out by often partisan, biased, and unqualified assessors whose colleges and regulatory oversight is so poor as to be non-existent. This failure, on the part of FSCO to ensure that the public is protected, has undermined the auto insurance industry's reputation and is causing serious harm to legitimate victims.

It stands to reason that if our government is going to legislate that we purchase a product then the government must also play a role in ensuring that that product serves the captive consumer. When half of all accident victims end up in the court system it is a loud and clear message that consumers are not satisfied and that the insurance product is not performing.

Accident victims would like to know why nothing is being done to correct this injustice and callous treatment when clearly the number of unpaid claims appears to exceed the number of claims properly handled by Ontario's insurers. We see in the 2009 Five Year Review Report, some 6 years ago, on pages 30, 36, 36 and 38 that the issue of IME/IE quality was raised. Yet there is still no improvement and these medico-legal reports are now much worse than in 2008-9. In fact, the quality of these medico-legal reports is now so bad that FSCO's own Arbitrators describe some of these reports as ***"'inaccurate, failed, misleading, defective, incomplete, deficient, not correct and flawed".***
http://www.ontla.on.ca/web/committee-proceedings/committee_transcripts_details.do?locale=en&BillID=&detailPage=/committee-

proceedings/transcripts/files_html/17-APR-2013_G007.htm&ParlCommID=8958&Business=Examen%20de%20l%27assurance-automobile&Date=2013-04-1#P197_47762

We recognise that there are some very good assessors out there who do their best for Ontario's vulnerable and often cognitively impaired accident victims. Some of these assessor associations have done extensive work to upgrade their knowledge and set criteria so that reports will be accurate reflections of injuries and treatments. But that is not enough. These are not obligatory qualifications and the many 'rogue' and partisan for-hire assessors that some insurers prefer are not going to comply unless there regulations in place that require that they meet qualification.

According to the 2009 Report on the Five Year Review of Automobile Insurance, FSCO was aware of the "***unqualified providers carrying out assessments***" and the ***"numerous "assessment mills" operating in the auto insurance system and providing claimants with inappropriate or unnecessary assessments given either the diagnosis and/or stage of recovery. "*** Despite the acknowledgement that a "***significant number of stakeholders expressed concern regarding the quality of insurer examination reports and the qualifications of providers conducting insurer examinations. Regulation 7/00 states that it is an unfair or deceptive act or practice to require a claimant to be examined by a person who is unqualified to conduct the examination. However, there are no standards or qualifications for assessors in the auto insurance system"*** nothing was done.
http://www.fsco.gov.on.ca/en/auto/5yrreview/Documents/FiveYearReviewReport.pdf

It is an empty and dangerous suggestion in the 2009 Review that Ontario's vulnerable accident victims are to rely on the various regulatory colleges for oversight and regulation when FSCO acknowledged in the past that Ontario's regulatory college oversight wasn't working and it was one of the reasons why the FSCO brought in the Designated Assessment Center (DAC) system in the first place. Once the DACs were abolished the IME/IE landscape was a free-for-all for unscrupulous insurers to use their preferred vendors of medical opinions to deflate and deny claims.

Ontario's colleges, in particular the College of Physicians and Surgeons of Ontario (CPSO) suffer from a perennial lack of will to hold their members, the IME/IE assessors, accountable when Ontario's accident victims complain about their insurer assessments. Their complaints are sloughed off or no substantial action is taken by the college to protect these very vulnerable and disabled MVA victims. Instead of being held accountable by their college there are remedial cautions, kept secret from the public, about the behaviour and harm of these assessors. This is compounded by the Health Professions Appeal and Review Board decisions when they review the college's decisions through the appeal process. The doctor's name is anonymous, reduced to initials, thereby ensuring that the public will be kept in the dark and the third party vendor of medical opinions will be protected from any accountability.
http://www.fairassociation.ca/wp-content/uploads/2013/08/FAIR-letter-to-CPSO-regarding-transparency-August-26-2013.pdf
http://www.fairassociation.ca/wp-content/uploads/2013/11/FAIR-response-to-CPSO-Draft-Transparency-Principles-November-11-13-.pdf

Recognising this serious problem with these for-hire medical assessors isn't good enough. The Anti-Fraud Task Force took the same road at their hearings in 2012 – suggesting reliance on the regulatory college system of oversight that they too were aware wasn't working. How did they know? Because FAIR

told the Task Force, our members told them, the statistics regarding the backlog in the system and the wording in the Arbitration decisions to describe the quality of these medical opinions and evidence told them. And still this fundamental issue of the quality of medical reports and testimony and how that is affecting accident victims and the quality and reputation of our civil justice system is ignored.

We saw no interest from the Anti-Fraud Task Force in respect to real regulation when it comes to reigning in and shutting down Ontario's insurer assessment mills and their shoddy and biased medical reports with accusations of symptom exaggeration. In fact we saw the opposite. We saw recommendations by the Anti-Fraud Task Force Panel to fine injured claimants $500 if they fail to submit to often useless or biased insurer assessments. Assessments that everyone in the industry and at FSCO knows are questionable, assessments without real oversight that everyone, except the general public and vulnerable accident victims, knows about.

Accident victims knew that little would be done when the Anti-Fraud Task Force commented that ***"There are rulings by judges and arbitrators on the public record. But the number of times that medical experts have been castigated for the quality, or independence, of their work has been minimal relative to the tens of thousands of claims paid and injuries reported after vehicle collisions each year. It is not known how many disputes over medical assessments are among the near 25,000 benefit claims that are up for mediation before the Financial Services Commission of Ontario."***
http://www.fin.gov.on.ca/en/autoinsurance/final-report.html

This totally ignores that many claimants never get to court before settling and it doesn't negate that these bogus reports exist in far too many 'medical' files.

Stresses on Our Court Systems and the DRS Report

In the DRS Final report Justice Cunningham has said ***"I believe some companies need to take a hard look at the level and quality of service being provided. A number of stakeholders suggested that insurers who do not adequately explain the reasons for denials seem to invite disputes."*** And in reference to the Anti-Fraud Task Force report recommendations: ***"the Superintendent recommended that health care professional associations and the insurance industry jointly develop standards for the delivery of third-party medical examinations, as well as qualifications for assessors. I understand that this recommendation has not been implemented to date."***

Despite that acknowledgement in the DRS report, MVA victims are told again to rely on Ontario's colleges for oversight and regulation. The best this panel could come up with was that an IME/IE assessor, whose report or testimony was found to be lacking either quality or qualifications, should not be paid for their appearance at a hearing. Too little, too late. Accident victims are waiting years without benefits based on these bogus medical reports and the majority of these cases never reach a hearing. Instead victims are financially punished by the very insurer they paid to help them in a time of need and forced to settle for far less than their case may be worth, and far less than they'll need for recovery based on these sub-standard medical reports. http://www.fairassociation.ca/wp-content/uploads/2013/09/FAIR-submission-to-the-Ontario-Dispute-Resolution-System-Review-September-20-2013.pdf

FAIR believes that Bill 171 is being rushed through legislation by our government and that 171 has nothing to do with fighting fraud or improving our insurance system except to enrich already wealthy insurance companies in Ontario. This is not a fraud fighting measure but a template for reducing benefits paid to injured MVA victims by way of marginalizing the rights of Ontario's disabled and injured citizens.

It is a serious matter to introduce legislation that is so murky and undefined and this causes uncertainty for accident victims when recent changes are not defined as retroactive or not – this leads to more uncertainty in the marketplace and some unscrupulous insurers have already taken advantage of this by increasing claim denials.

What kind of government creates laws that discriminate against injured and disabled citizens by denying them the same access to justice that every other citizen enjoys in a democratic society? Why remove the disincentives for insurers who delay and deny legitimate claims by decreasing prejudgment interest rates and throwing away 'special awards' for claimants who have been unfairly abused at the hands of their insurer? It's like declaring war on vulnerable MVA victims and it has nothing to do with fighting fraud and everything to do with putting obstacles and delays in the way of access to benefits.

The poor quality of these medical opinions is the 'tool in the toolbox' preferred by some insurers whose delay and deny tactics are the core reason for the backlog in our courts systems in the first place.

Bill 171 will leave us with a dishonest system based on too often flawed and biased medico-legal opinion reports that are used to deflate and deny legitimate claims – but it will be faster. Not better, not honest, not helpful and certainly not fair or just.

The DRS Panel has made recommendations to strip injured claimants of the right to take their cases to court. Instead of punishing rogue insurer assessors with fines or fraud charges – we see 'special awards' being eliminated and the power of FSCO Arbitrators to refer insurer misconduct to the Market Conduct Branch removed. No more remedies for wrongful claims handling practices and all of these measures hurt MVA victims and reward insurers for abusive conduct and delays.

The DRS report recommends all hearings under the cap of $10,000.00 be paper hearings without any personal appearance from the accident victim to expedite cases through the system. There should always be an option for in-person attendance at hearings so that an accident victim can present their side. We think that it is very important that claimants not be shut out of the process. We think that accident victims should have the same rights as all other Ontarians. http://www.fairassociation.ca/wp-content/uploads/2014/03/FAIR-letter-to-ADR-Reform-Oct-11-2013.pdf

FAIR does not support the end of the use of trained Arbitrators for hearings on SABs benefits. While this is not explicit in the DRS recommendations the use of the term Tribunal to describe these hearings has caused some concern about the quality of the hearings in a new system. http://www.fairassociation.ca/wp-content/uploads/2013/12/FAIR-response-to-the-Ontario-Dispute-Resolution-System-Review-Interim-Report-December-2-2013.pdf

There's a concern regarding proposed limits on the length of the medical evidence reports. For those with a serious or catastrophic injury a report consisting of only a couple of pages would act as a systemic way of minimizing the injuries and reducing insurer payouts. That's not justice. Failing to act ensures that justice for accident victims will be just as unfair, and just as dishonest, but it will be faster.

Who Foots the Bill?

There is no upside here for the taxpaying public either when the injured or disabled person is without funds to look after themselves, they will have no choice but to access public services. Unfortunately some of FAIR's members have had their disability claims denied through CPP and ODSP because of the bogus medical file their insurer has built up in order to deny their claim for benefits. So there is a ripple effect from these bogus reports, one that further harms the accident victim and long after the insurance claim ends.

There were plenty of consumer and stakeholder submissions to the last 5 Year Review that brought this IME/IE issue forward, and the quality of medical assessments have been a subject of discussions and concern at every hearing since, including the Auto Insurance Review at the Standing Committee in 2012 and 2013.

For accident victims the losses AFTER a serious car accident are often caused by their insurer refusing responsibility and their failure to live up to the terms of their contract or because of some poorly written or unqualified medical report used to deflate their claim and minimize their injuries. People are unable to recover, unable to return to work or hold on to their jobs, they often lose their homes and their families are traumatized and torn apart by the negative experience of making a claim. Many victims often develop PTSD from the claim experience itself which many describe as 'hell'.

Accident victims who are on the lucky side of the crap-shoot that getting benefits has become, and who actually do get paid are impoverished by the low base payment of $400/week. This amount needs to be changed to represent what it actually costs to live in Ontario and should reflect the average wage. It is a minimum wage level of income replacement and an amount that victims are unable to support themselves on. It's an insult to believe that those who are injured require less money to live on when the opposite is closer to the truth.

Many of FAIR's members complain that their insurer spent more on assessments to deny treatment than the actual treatment itself. There are cases in the system where individuals have attended dozens of expensive IME/IEs at a cost in excess of $100,000 so an insurer could deny treatment plans that were less than $20,000 in total. Of course during all of these assessments, the victim isn't in treatment but rather is getting worse with the abuses of the assessment process and the stress caused by the denial of the benefits they need to survive. http://www.fairassociation.ca/wp-content/uploads/2013/02/FAIR-Submission-to-Anti-Fraud-Task-Force-Status-Update-August-27-2012.pdf

We now have an insurance industry that appears to be spending more money to assess injuries than it does treating those injuries and this practice drives the claims costs up dramatically. Some insurers will assess victims until they get the report they want. Or pay exorbitant prices to assessors for preparation

for court hearings that equates to more than they would pay in a year of income replacement. Those are the same claims costs that Ontario's insurers complain about and that are generated at their end of the business. Rather than control their spending, it has become a game of slash the benefits at every opportunity to preserve their profit margins. It's irresponsible to pass on the expenses of the often incompetent insurer or their deceptive business practices onto the claimant or pass these costs on to all of Ontario's drivers through premiums.

Regulation Ontario Regulation 347/13

We see this slash and burn mentality with the undemocratic passage of Regulation Ontario Regulation 347/13. It is behaviour we expect of the insurance industry but not of our own government. We expect a transparent and open process that includes the interests of accident victims and not just Ontario's insurers. These new restrictions and thresholds seem designed to disrupt and financially punish families of auto accident survivors who care for their often cognitively impaired or catastrophically injured family members. This legislation was clearly was done without thought and certainly without any consultation with stakeholders other than Ontario's insurers. It is a demonstration of the far too-close relationship between the insurance industry and the government whose legislation reads like the insurance industry's wish list. http://www.fairassociation.ca/wp-content/uploads/2014/01/FAIR-submission-to-2014-Pre-Budget-Consultations-Jan-23-2014.pdf

At FAIR we wonder how much discussion the proposals in the DRS Review have actually had. We have not yet seen the report on the hearings of The Standing Committee on General Government AUTOMOBILE INSURANCE REVIEW that started in 2012 or the KPMG Automobile Insurance Transparency and Accountability Expert Report. We would have hoped that our government would consider all of the information available to them when making substantial changes to our insurance regulations. http://www.fairassociation.ca/wp-content/uploads/2014/03/FAIR-Open-Letter-to-Wynne-Sousa-Matthews-March-20-2014.pdf

CAT Catastrophic Impairment Panel Report

We would like to see an end put to the 2013 Catastrophic Panel Report recommendations given that only the insurance industry stakeholders agree with the findings of this panel. All other stakeholders, including FAIR disagree strongly with these recommendations. http://www.fairassociation.ca/wp-content/uploads/2013/09/FAIR-response-to-Stakeholder-Roundtable-on-Catastrophic-Impairment-September-5-2013.pdf

Panel Selection

FSCO and the Minister of Finance continue to put together panels and consultations and studies like the MIG study, the CAT panel and now the DRS Review using the same partisan and biased consultants and policymakers that have had influence on this present system for many years. If the system is broken, why does the FSCO and the Ministry continue consulting and listening to the same architects of the mess we have today? Is it any wonder that things just keep getting worse?

MIG

The Minor Injury Guideline study will not be available for some years to come - and yet the legislation is already in place and benefits are reduced without proper consideration or discussion.

The MIG was never intended to capture 80-85% of all claims. It was intended to facilitate treatment for lesser injuries without the necessity for exhaustive assessments. It has morphed into a tool for denial and has trapped seriously injured accident victims to rehabilitation limits that do not reasonably address their injuries. What was designed to facilitate treatment has become an obstacle for accident victims.

The MIG, like all other insurer inspired thresholds and limitations have increased the litigation in the system - it can hardly be surprising given the uncertainty about who should and shouldn't be in the MIG. Some insurers have taken advantage of this uncertainty to stall and delay claims. These finer points should have been addressed before the legislation was put into effect.

Information Available to the Public Regarding Insurance

There is a real lack of information regarding the coverage accident victims have following an MVA. FSCO appears to have left the responsibility to inform consumers in the hands of the Insurance Bureau of Canada. The problem with asking a for profit organization whose only members are Ontario's insurance companies to inform the public about decreased benefits should be apparent. It is the job of the IBC to anticipate and lobby for "***opportunities to identify, shape and influence change in support of members' business needs".***

FSCO needs to do a far better job at public awareness so that accident victims know what they are paying for and what they are entitled to.

Consumers should know what treatment for traumatic injuries cost and be aware that $50,000 sounds like a lot of money to pay out on a claim but if the injuries are serious, the costs to rehabilitate an MVA victim can be substantial. Information that is distorted by viewpoint or need to make greater profit isn't providing the information that consumers need to make informed choices.

Conclusion

FAIR hopes that with this 3 Year Review that the Superintendent will put the accident victims' interests and well-being at the center of any recommendations. After all, this system was built to serve that purpose, to make sure that we have adequate coverage at a reasonable price and not to solely serve the interests of insurance companies.

Thank you for the opportunity to have our concerns heard.

FAIR Association of Victims for Accident Insurance Reform

http://www.fairassociation.ca/

From http://www.fairassociation.ca/the-independent-medical-examination-imeie/

Singh and State Farm [+] Arbitration, 2014-02-21, Reg 403/96.
Expenses FSCO 4128.
I also found that State Farm did unreasonably delay the IRBs to which Mrs. Singh was ultimately entitled. It had no reasonable answer for not reconsidering her benefits after May 2, 2008 and relied on defective or incomplete reports to terminate those benefits, hence the special award.

DE v GC, 2013 CanLII 55436 (ON HPARB) — 2013-09-05 http://canlii.ca/t/g0c3b

4. As part of her practice as a registered physiotherapist, the Respondent is regularly retained by medical assessment companies and insurers as an independent third party assessor to perform examinations to assist in determining the reasonableness and necessity of continued coverage for physiotherapy treatment.

5. In performing her assessments, the Respondent reviews the medical records provided to her by the insurer and may conduct an examination, which includes taking a history, and performing a physical examination and testing of the subject. In other cases, the Respondent bases her assessment solely on a paper review of the subject's medical file. The nature of the assessment and the content of the medical record reviewed by the Respondent are determined by the insurer.

6. The Applicant was referred to the Respondent for six independent assessments. The Respondent provided in-person, physical examinations of the Applicant on four occasions and conducted two assessments based on a paper review of the Applicant's medical records.

7. The Respondent's assessments of the Applicant done on December 7, 2010 and May 17, 2012 each concluded that the proposed treatment plans were entirely reasonable and necessary. The assessments done on March 24, 2011 and July 14, 2011 concluded that the proposed treatment plans were partially reasonable and necessary. The paper review assessments done on August 29, 2011 and March 12, 2012 concluded that the proposed treatment plans were not reasonably necessary.

The Complaint and the Response

8. The Applicant complained:

- The Respondent repeatedly made negative comments about the Applicant's treating physiotherapist. The Respondent stated that his physiotherapist's "lack of information provided in reports is hurting [the Applicant] and [resulting in him] having to go through IME after IME";
- The Respondent submitted reports that were "riddled with mistakes" and she quoted him making statements that are "completely ludicrous";
- He believes that the Respondent's "opinion seems to be favouring [his] insurance company's bottom line";
- The Respondent failed to amend her report dated March 13, 2012 after additional documentation was provided to her; and

- At his assessment on July 14, 2011, the Respondent "suggested to [him] that it might be in the best interest for [her] to call [his treating physiotherapist] directly" for clarification of an OCF-18 form; however, the Respondent failed to follow up with the treating physiotherapist.

9. The Respondent responded to the areas of concern raised by the Applicant as follows:

- She advised the Applicant that some of the treatment plans submitted by his treating physiotherapist lacked an explanation as to why the proposed treatment was reasonable and necessary, and that this resulted in the Applicant having to undergo repeated assessments. She meant no disrespect to the Applicant's treating physiotherapist and, in fact, complimented the progress the Applicant was making under his treating physiotherapist.
- The Respondent acknowledged that there were some minor inaccuracies in her reports but stated that she relied on information the insurer and the Applicant provided to her and noted that none of the inaccuracies was material to the conclusions in her assessment reports.
- The Respondent acknowledged that she does copy basic information from one report to another, citing that this is common practice, and thus avoids having to cover this prior ground each time.
- The Respondent stated that her reports were not biased in favour of the insurer and noted that her opinions were, for the most part, favourable to the Applicant.
- The Respondent stated that she was not aware of any further information being provided to her after the paper review of March 13, 2012 and noted that she was never asked by the insurer to complete an addendum report based on new information.
- The Respondent denied that she offered to contact the Applicant's treating physiotherapist and stated that it was not her usual practice to do so during the assessment process. She suggested that the Applicant may have confused this point with her willingness to speak with treating medical professionals *after* her assessment and report were completed.

The Committee's Investigation and Decision

10. The Committee investigated the complaint and decided to provide the Respondent advice about ensuring the accuracy of her reports and the need to ensure that her practice in this regard is appropriate and to take no further action.

JV v HAP, 2013 CanLII 59329 (ON HPARB) — 2013-09-20 http://canlii.ca/t/g0n2f

The Complaint and the Response

5. The Applicant complained about the Respondent's examination and conclusion. She took issue with many aspects of the assessment. For example, the Respondent concluded that the Applicant suffered from significant lower back pain several times a month while the Applicant asserted she experiences such pain every day. The Respondent noted a curvature of the spine in the IME report, which the Applicant complained was false. The Respondent concluded that the Applicant was not impaired by any accident related injury from continuing her schooling and the Applicant complained that this assessment was false.

6. In addition, the Applicant complained about the way in which the Respondent conducted the IME, alleging that the Respondent rushed through the assessment, failed to conduct a physical examination, and failed to consider x-ray and radiographic reports.

7. The Respondent provided a detailed rebuttal of the allegations, explaining the basis for each conclusion in his observations during the IME or the available medical records. He noted that all available records were reviewed, and that a physical examination

was not necessary for the IME. Further, he denied that the IME was rushed, or conducted in an improper fashion.

MC v KE, 2013 CanLII 55435 (ON HPARB), 2013-09-04 http://canlii.ca/t/g0c3g

7. [...]The Respondent notified the Committee that, through the complaints process, she had discovered that Riverfront Medical Services (Riverfront), the company through which the Applicant's assessment was contracted, had changed the Respondent's report without her prior knowledge or consent.

9. As a result of its investigation, the Committee decided to take no further action, noting that the Respondent reported information that she considered to be accurate and that there did not appear to be any indication that the Respondent intentionally falsified factual information in the report or that she misrepresented information about the Applicant's abilities during the assessment.

10. However, the Committee did express concern about the information uncovered during the course of the investigation related to Riverfront having altered the Respondent's report. The Committee noted the "egregious" impact that these changes could have had on the Applicant's entitlement to benefits. In the result, the Committee decided to offer advice to the Respondent about the importance of ensuring that she personally reviews and approves any assessment report she completes prior to the report being issued.

Macdonald v. Sun Life Assurance Company of Canada, 2006 CanLII 41669 (ON SC),http://canlii.ca/t/1q596 2006-12-13

[1] In the course of this jury trial I ruled that Dr. Frank Lipson, who had conducted a defence medical of the plaintiff, not be permitted to testify as an expert witness on behalf of the defence. Dr. Lipson had testified that a medical report purportedly signed by him had not been signed by him. He stated that his signature stamp had been affixed to the report without his authority by an individual at Riverfront Medical Evaluations Limited (Riverfront) the company who had retained him to conduct the defence medical. [...]

[2] I have deliberated for a very long time before delivering these reasons. Although the action out of which the problem arose has long been concluded, this case raises vexing issues as to what role may be properly played by organizations such as Riverfront in the formulation of an expert witness' opinion.

[43] Twenty percent of their physicians conduct their assessments off site in which case the physicians will prepare their reports and send it to Riverfront by fax or other electronic means. Riverfront performs its quality control function and sends the report to the physician for comments if required. After consultation with the physician, the report will be prepared on Riverfront's letterhead and signed by the physician or as in the case at bar a signature stamp is affixed to the report, which is sent to the referring client.

[44] In many cases Riverfront has a signature stamp of the doctor, which the doctor authorizes them in writing to use. Dr. Levy produced a letter dated January 5, 2004 in which Dr. Lipson authorized Riverfront to utilize a signature stamp/electronic signature when issuing assessment reports – "when I am unable to directly provide my signature". The authorization provides that signature stamp would only be used "once I have approved the final copy of my report".

[88] It is stating the obvious that an expert's report delivered for the purpose of compliance with the *Rules of Civil Procedure* and the *Evidence Act* is an extremely important document. Anyone involved in the preparation of such reports must know that courts place a very strong reliance on the contents of these reports and that the proper administration of justice demands that these reports accurately reflect the opinion of the expert who has written them. The requirement in the *Rules of Civil Procedure* and the *Evidence Act* that the expert sign the report is intended to provide assurance that the statements in the report are those of the expert.

[100] Expert witnesses play a vital role in proceedings before the courts both in civil and in criminal matters. In personal injury actions in particular, the evidence of the expert witness may be the determining factor in the resolution of the plaintiff's claim In the case of health practitioners, section 52 of the *Evidence Act* provides under certain conditions, the report may be filed in place of the *viva voce* evidence of the health practitioners. The court is entitled to assume that the report represents the impartial opinion of the expert.

[101] In my view Riverfront in this case, went far beyond what can be considered a proper "quality control" function. While I am not prepared to find that they were motivated by a desire to assist the defendant, nonetheless I find their actions constituted an unwarranted and undesirable interference with the proper function of an expert witness.

[102] The function of an expert witness is to provide an independent and unbiased opinion for the assistance of the court. An expert witness' evidence should be and should be seen to be the independent product of the expert uninfluenced as to form and content by the exigencies of litigation.[2] This principle has often been cited with approval in our courts, and has been considered a factor to be considered in asessing the weight to be given to the expert's testimony. It has occasionally been treated as the basis for the disqualification of the witness entirely.[3]

[103] In my view any activity that may tend to detract from this all-important objective diminishes the integrity of the litigation and trial process and should be met with appropriate sanctions designed to send a clear message that such conduct will not be tolerated.

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