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FAIR feedback on CPSO draft Third Party Medical Reports policy November 16, 2020
Via email**:** thirdpartyexpert@cpso.on.ca

FAIR (Fair Association of Victims for Accident Insurance Reform) is a grassroots not-for-profit organization of Ontario's injured MVA victims who have struggled with the current auto insurance system.

In Ontario auto insurers spend more assessing car crash injuries than providing treatment for injuries. According to 2019 data about 1/3 of all dollars spent on medical and rehabilitation are dollars spent on insurer medical examinations and reports with an unknown amount paid to medical experts who testify in court.

There is much at stake in terms of timely recovery for these often traumatically injured patients and the quality of their lives post accident depends on what transpires when they are sent to a medical examination. Our members see a marked difference between the exams and reports arranged for them either through their lawyer or in the OHIP system and the problematic insurer arranged IMEs. For the purpose of this submission our reference to IMEs are a reference to Insurer Medical Examinations and the reports and opinions emanating from those encounters in an auto insurance claim context. Our comments are focused on the Third Party Medical Reports draft policy and not the Advice document.

It is very disappointing to read within a recent College of Physician and Surgeons of Ontario INQUIRIES, COMPLAINTS AND REPORTS COMMITTEE (ICRC) decision (#1111896, Sept 1, 2020) that **"The College does not regulate the quality control of third-party IME for the province of Ontario and the insurance industry."** And that the IRC feels that the **"College is not the correct forum to dispute the interpretation and application of the guidelines regarding chronic pain and disability."** This begs the question of what will CPSO do to fix an obvious disconnect between the CPSO's duty to protect the health and safety of Ontario's patients and the ICRC stated position on an important point that completely undermines the effort going into this consultation? And if the regulator doesn't want to regulate – who will?

The revelation from the CPSO ICRC supports what injured auto crash survivors have experienced when they have complained to CPSO about the shoddy treatment that takes place during insurer medical examinations. The lack of action taken by the CPSO and ICRC to protect these vulnerable patients is especially concerning given that legislators who crafted the Auto Insurance Act anticipated that CPSO would perform regulatory oversight and act as a protection for the public interest.

We can see that CPSO has put considerable effort into this consultation and we appreciate that some of the concerns from our members and the public at large have been part of the consideration in this Draft policy.

Does the draft policy serve and protect the public interest?

In **lines 14-20** it is said that the policy is about conducting examinations and providing opinions "for a third party process and not for the provision of health care". This ignores what the IME purpose is usually about which is access to recovery resources/treatments and the IME provider acts as gatekeeper to the treatments or resources at question. IME practitioners are in that gatekeeper seat and as such should owe a duty of care to these patients.

Owing patients' a duty of care and providing treatment are not mutually exclusive and one can be owed without the other being provided. Patients will never be able to understand how it is that they are at risk in an IME situation because it is at odds with a common expectation of 'do no harm' and 'duty of care'. These are patients on a quest for recovery, not dollars and they are the only participant in the process interested in their recovery.

Does the draft policy contain practical expectations for physicians?
Does the draft policy strike the right balance balance between serving and protecting the public interest and being practical for physicians?

Its striking how the contortion to avoid duty of care for this group of patients means avoiding a second point; does this policy even protect other CPSO members who treat this same set of patients or our healthcare system itself? This means ignoring the subject of the IME is definitely someone's patient and that healthcare harm occurs through treatments denied. Ultimately that treating CPSO member will have to find a competent specialist(s) to provide opinions that are focused on helping their patient and not helping the hands of private insurers that provide $ for opinions. Those treating CPSO members must deal with the fall-out of a devastated patient without adequate supports. It is definitely not in the public's interest to have necessary recovery resources denied so that patients already struggling are downloaded onto the public purse via OW and ODSP and dumped onto the inadequate and overloaded OHIP system.

The physician role in Third Party processes in **lines 61-67** "is to provide information and/or opinions to the third party involved in the process and not to decide the outcome of the third party process or provide health care" takes us back again to the real role played by these assessors, the questions put to them means their answers are all shaped by their role as gatekeeper. The CPSO may wish that the "final outcome (for instance, decisions regarding eligibility for benefits) is not determined by the physician but rather by the relevant decision makers in the third party process" but the questions posed to the assessors and the answers they give make that untrue and it is an impractical view of the process.

Regarding Consent issues addressed in **lines 72-91.** There appears to be problems identified in this CPSO Draft document as well as significant questions about the IME providers handling of drivers licenses and various IME documents we've brought to the Colleges attention in the past that suggest there is a problem with a lack of consistency. CPSO might consider actively creating the documents around Consent with the assistance of the Privacy Commissioner so there is uniformity that conforms to PIPEDA standards and protects patients.

We do see that there has been some tightening of the wording surrounding Scope of Practice & Area of Expertise in **lines 117-122** in an effort to line-up the public expectation with the reality of where CPSO member's expertise actually are. The inflation of credentials and 'expertise' has been a big problem that has poisoned many IME reports and opinion evidence and routinely undermines recovery. Much of the damage has been through disturbing attacks on the credibility of patients. This seems to be unique to this subset of IME vendors because we don't see personal attacks in OHIP generated medical reports and we should not be seeing this type of shameful and unprofessional attacks in IME reports. There should be consideration given to directly address this type of personal credibility attack which is so harmful. Words matter and disparaging language in a medical report shouldn't be tolerated especially when it is so clearly designed to harm the patient and influence any trier-of-fact should the patient have to go to court. **Lines 155-161** do cover this but given how common this type of healthcare harm is in IME reports we think it should be much more specific.

Are the draft policy expectations proportionate to the level of risk physician participation in third party processes has for patients and individuals?

Ontario's car crash patients operate in a world that works against their recovery and this made possible by the lack of action by CPSO to protect them as patients. This is evidenced by the very idea that people feel the need to record these medical encounters and that so many CPSO members mount personal credibility attacks on them in order to protect their insurer generated income stream. Your members continue to hold themselves out as experts on pain management, on sports injuries, and in comments that are psychological in nature within reports that are often written by general practitioners who do not hold any specialist credentials. It's clear this end of the CPSO membership isn't getting the pro-active oversight Ontario patients expect. It is also undermining College credibility while creating an inordinate number of court cases and patients who are impoverished while on inadequate social supports that literally means they are starving, not recovering.

Ontario should always be patient recovery first. Patient centric would mean that somewhere in **lines 196-217** it would have been noticed that the patient, who has the most to lose in terms of timely treatment, should also be informed when a report is going to be late.

If a blanket 'Duty of Care' protection was in place then splitting hairs over who gets informed about a person's unexpected medical issues would mean that not advising the patient affected wouldn't be acceptable to the College. Not in a patient first, recovery first climate such as all other Ontario patients enjoy. **Lines 258-263** put disclosing information to a patient about their own health in question and that definitely does not protect the public or patients.

Thank you for the opportunity to input on these important issues facing Ontario's patients. We hope our comments will make a difference and put patient healthcare interests first.

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