Back to the Future
In Search of the Mythical Doctor
(Background Document)

With the introduction of Ontario Regulation 546/05 on March 1, 2006, there has been a dramatic shift in the independent assessment process in the Province of Ontario. The trend in dispute resolution has reverted "Back to the Future" of the duelling "expert opinion" rendered by a mythical doctor, reportedly capable of commenting on all issues. This practice was common to independent assessment prior to the introduction of Bill 68 - Ontario Motorist Protection Plan (OMPP) in June 22, 1990 and the implementation of Bill 164 in 1994. This current, re-emerging, litigious practise with its significant associated costs was one of the hallmarks of auto insurance in the late 1980s and a major driving factor, at the time, for the insurance industry to seek auto insurance reform.

Since June 1990, several experiments involving the provision of expert assessments have been implemented in the Province of Ontario. From January 1994 until March 2006, expert opinions were principally rendered through the Designated Assessment Centre (DAC) process. While this system had flaws and critics, the DAC process had many redeeming features. It was the NDP Government of Premier Bob Rae that introduced Bill 164 which led to the implementation of the "neutral government Designated Assessment Centres (DACs)." The DACs were a system of 107 government appointed, province wide, facilities which were introduced to facilitate the resolution of disputes between insurers and claimants over medical & rehabilitation, disability, residual earning capacity, and catastrophic impairment benefit disputes, thereby reducing the need for mediation or arbitration. Their mandate was to provide insurers and claimants with prompt, impartial assessments, which were consistent with best practices.

In November 1996, the Progressive Conservative Government of Premier Mike Harris introduced the *Automobile Insurance Rate Stability Act (Bill 59)* which led to the establishment of an Ontario Insurance Commission (OIC), now Financial Service Services Commission of Ontario (FSCO) controlled DAC Committee comprised of auto insurance stakeholders. The DAC Committee operated on the principle that DACs were an integral component of the alternative dispute resolution process. The DAC Committee was charged with the responsibility of ensuring that all DACs met this mandate and provided opinions in a fair and cost-effective manner that would also meet *Bill 59*'s goal of stabilizing insurance rates for all automobile drivers in Ontario. A task of the DAC process was that assessments were done on a peer-to-peer basis and that assessors were required to demonstrate that they possessed the requisite expertise through education, training and experience to address a benefit in dispute.

On October 1, 2003, Bill 198 was implemented by the Progressive Conservative Government of Premier Ernie Eves and new regulations saw little substantive change to the independent assessment process aside from providing DAC assessors with protection from litigation for opinions rendered in good faith.

In November 2003, Superintendent of Insurance, Mr. Bryan Davies, released a comprehensive report on the DAC system which had been commissioned by the Progressive Conservative government in July 2003. This report to the new Liberal Government's Minister of Finance, Mr. Greg Sorbara, recommended the continuation of the DAC system but with operational changes.

Instead of maintaining the DAC system, the Liberal Government of Premier Dalton McGuinty proposed in March 2004, an Expert Assessor Network (EAN) process as a replacement. The premise for this EAN proposal was based on data published in a 2003 pre-election Liberal Party White Paper which promised to eliminate the DAC system. This data was subsequently revealed to contain significant flaws. It was proposed that this new network of medical expert assessors would provide customer focused assessments across the province. These new assessments would respond to questions posed by insurers or insured persons and their primary practitioner, focusing on a broad range of medical, rehabilitation and disability issues. The network would deliver prompt, standardized, "cost-effective" assessments with conclusions and recommendations based on scientific evidence and best practices.

The government received 97 submissions to their EAN proposal, which was roundly criticized by stakeholders. While the majority of the espoused principles of assessment were already part of the DAC process, the controversial proposal of having a physician serve as a gate-keeper to the system was not endorsed. The overall consensus opinion from the various health professions and stakeholder groups was that limiting the first ("lead assessor") or entry level of independent assessment in the EAN to a roster consisting of only physicians was inappropriate.

The EAN Report to the Superintendent of Financial Services Commission of Ontario by the government's appointed consultant clearly identified the following:

a. the requisite expertise to provide an expert opinion did not reside only in the medical profession;
b. there were few physicians in Ontario with the requisite education, training and experience with resultant expertise in disability management or occupational health to address the majority of cases and there were few physicians in Ontario with the experience and expertise in diagnosing and treating injuries related to automobile accidents;
c. chiropractors, physiotherapists, occupational therapists, amongst other professions, had equal or greater expertise in these issues;

d. there were few physicians with specialized knowledge in auto insurance, SABS and general care relating to the auto accident victim population;
e. there was a lack of administrative capability and capacity in physicians' offices to perform key clerical requirements revolving around assessments;
f. the use of unqualified assessors puts the insurer at substantial risk of a claim for bad faith or punitive damages;
g. a physician gatekeeper model would exacerbate a shortage of qualified physicians in smaller urban and rural centres, necessitating insurers having to cover additional transportation costs for physicians who are sent in from larger urban centres;
h. the use of physicians only would result in a general exacerbation of an already chronic physician shortage in the public health care system, resulting in further increases in wait times for patients with non-auto insurance accident related impairments, which is also contrary to the Government's focus on primary care reform and making better use of non-physician practitioners;
i. the primary use of physician assessors could potentially damage the normal referral process between family physicians and medical specialists in primary care scenarios, especially when an opinion was rendered contrary to the opinion of the family physician, and especially in smaller communities where the pool of medical specialists is smaller;
j. it creates unreasonable and unnecessary delays in treatment with a resultant increase in chronicity of impairment for auto accident victims;
k. it would interfere with a patient's choice of approach to evaluation and treatment, a hallmark of Canada's and Ontario's health care system and a key principle of the Regulated Health Professions Act and the Romanow Report;
l. it would fail to make appropriate use of the full range of professional expertise in the "rehabilitative model" of care which focuses on the restoration of function;
m. it will not be cost effective because many of these physician assessments could be done by other regulated practitioners in accordance with professional Standards of Practice established by their Regulatory Colleges;
n. reports could not be treated as prima facie evidence in arbitration or court cases if there was limited ability to provide alternative compelling evidence to the contrary; and
o. the legal community would spend appropriate sums of money to generate other compelling evidence where the assessment was not in favour of their client.

With respect to assessors, some of government appointed consultant's recommendations were that:

a. assessors should be able to demonstrate a minimum of three to five years of clinical practice that balances patient care with independent assessment;
b. assessors should be required to demonstrate evidence of requisite training, education and experience;
c. assessors should be required to demonstrate ongoing continuing education relative to accident benefits;
d. there was significant discussion about the lack of qualifications of physicians to conduct assessments in all areas of a claim for accident benefits and that other regulated health professionals such as chiropractors, kinesiologists, occupational therapists, physiotherapists, and psychologists should be included in the system; and
e. this multidisciplinary approach is supported in the position statement from the Ministry of Health and Long-term Care that a physician centric model is not aligned with the inter disciplinary model of primary care that the Ministry of Health is actively promoting and implementing in Ontario.

The final report of the government's consultant during the Expert Assessment Network (EAN) consultations concluded that: *"No expert assessors capable of addressing the full range of impairments presented in the automobile accident injured population exists. No one health practitioner is in a position to make qualified assessments in areas outside their expertise. This has long been recognized in the courts. The use of a single assessor will become fodder for lawyers who will challenge these decisions. Assessment fees may go down but Arbitration and court costs will go up."* The report further concludes that *"While a free market system which would allow the insured and insurer control of the timing, cost and variety of assessments that there would be no control over the quality or choice of assessor. With the time it presently takes to get to arbitration or through a court, an insured can sometimes be without needed treatment or income for significant periods. One would like to think that in the present climate of punitive damages that insurers would do their best to make reasonable decisions on files with supporting medical evidence. Unfortunately, we do not live in a perfect world."*

On March 1, 2006, the McGuinty Liberal Government introduced new regulations abolishing the DAC system, allowing insurers the ability to choose their own Section 42 assessors. In an effort to ensure that insurers did not abuse this process, Ontario Regulation 7/00 (Unfair or Deceptive Acts or Practices (UDAPs)) was introduced. The UDAPs made it clear that certain acts were not permitted.

Pursuant to the UDAPs, if an insurer did any of the following, it would be deemed to be an "unfair or deceptive act or practice":

a. Determines that a person is not entitled to a benefit, without first getting a report under s. 42 when required to do so;
b. Misrepresents or unfairly presents the findings or conclusions of the s. 42 examination;
c. Arranges a s. 42 assessment with a person who is not qualified to conduct the examination;
d. Requires the victim to attend a s. 42 assessment that is not reasonably required; and
e. Fails to get written consent of the victim for a pre-claim examination.

In 2008, the Liberal Government undertook a further review of Ontario's Auto Insurance system as mandated by regulation every five years. Ninety submissions were received and a common issue expressed by stakeholders concerned the quality of insurer examination reports and the qualifications of providers conducting insurer examinations. Stakeholders considered that with the demise of the DAC system, members of the insurance industry and some independent assessment companies were often utilizing marginally qualified examiners who did not have the education, training and experience with requisite expertise to perform independent examinations. Despite Regulation 7/00 outlining that it was an unfair or deceptive act or practice to require a claimant to be examined by a person who was not qualified to conduct the examination there was no mechanism to enforce its compliance aside from the imposition of bad faith claims penalties against insurers at arbitration. Without a formal mechanism of enforcement, insurers continued to be free to utilize which ever assessor they deemed appropriate steering away from a peer-review process. It was felt by stakeholders that this standard of practice was contributing to a significant increase in mediation and arbitration applications through the Dispute Resolution Services (DRS) process at FSCO.

In September 1, 2010, Bill 198 was introduced which brought about substantive changes to the SABS. The Pre-Approved Framework Guideline for Grade I and II Whiplash Associated Disorders was replaced by a new Minor Injury Guideline which had not been subject to scientific review. For those diagnosed with a "minor injury," medical and rehabilitation and assessment expenses are now limited to $3,500. Attendant care or an in-home assessment is no longer available regardless of optional coverage if the claimant is within the Minor Injury Guideline. "Minor Injuries" are broadly defined as a "sprains, strains, whiplash associated disorders, contusions, abrasions, lacerations or subluxations and any clinically associated sequelae."

Of current significance is that the Province of Nova Scotia, which had a cap on minor injury rehabilitation of $2500, implemented new changes in March 2010 raising the cap to $7500 and broadened the definitions allowing chiropractors and physiotherapists increased roles in assessment and treatment. This increase in benefits added approximately $24 annually to the average premium. The cap is indexed annually and regulatory changes allow the introduction of optional full tort. These changes, coupled with higher cap levels in other provinces, and the planned future review of the Minor Injury Guideline, only emphasize why utilizing the most qualified assessors to provide expert opinions will become increasingly critical.

The definition of a minor injury disorder seem to further "medicalize" auto insurance policies leading to a further increase in mediation and arbitration applications. In addition, the definition of minor injury does not appear to appropriately address concomitant psychological impairment, and whether a psychological impairment takes an insured person out of the Minor Injury Guideline.

With respect to independent assessments, three significant changes emerged. The first change was an introduction of a hard cap of $2000 per assessment; the second eliminated under the UDAP's an insurer's requirement to arrange an assessment with a person who is qualified to conduct the examination; and the third was the elimination of rebuttal assessments, providing insured individuals with a limited option to challenge inappropriate opinions by unqualified assessors.

The elimination of the UDAPs concerning independent assessment has led some insurers to engage in other assessment practices which most stakeholders consider to be acting in bad faith. Members of the insurance industry are now routinely booking assessments exclusively with physicians to review questions on a wide scale of musculoskeletal and psychological impairments and treatments. Stakeholders consider that most physicians do not have the requisite education, training, experience and expertise to be able to provide opinions concerning disputed benefits. Additionally, due to a lack of qualified physicians and an increased unwillingness of physicians to perform independent assessments, it is becoming common practice for insurers to schedule assessments 4 to 6 months from the date of dispute and in the interim period deny legitimate accident victims access to appropriate benefits. These delays only serve to further increase the potential for the development of chronic impairments and drive further costs into the system.

Preliminary anecdotal stories of inappropriate behaviours reportedly include insurers:

- requesting psychiatrists do in-home functional assessments on patients with minor psychological impairments;

- requesting an orthopaedic surgeon to comment on the need for an orthopaedic mattress in lieu of a chiropractic specialist who serves as the Medical Director for Sealy Canada;
- asking family physicians to comment on the need and scope of such services as chiropractic, physiotherapy, and occupational therapy interventions for which they have little to no training despite the insured having already being placed in the Minor Injury Guideline;
- requesting a physician to determine if an insured has minor injuries despite sustaining serious injuries requiring extended hospitalization;
- increasingly utilizing claims processors, with little to no regulated health profession educational background, versus claims adjusters to requisition independent assessments; and
- routinely withdrawing assessment requests from assessment facilities who question claims processors about the appropriateness of certain physician only assessments and submitting the same assessment to another facility willing to comply.

It is a common knowledge that musculoskeletal conditions affect 1 in 5 adults and are the number one cause of physical disability, the number one reason for long term treatment, and the second most common reason for consulting a health professional. In many countries musculoskeletal conditions constitute 10% - 20% of all primary care visits and they are common as comorbidities. The World Health Organization has identified low-back pain as the leading cause of disability in society.

Despite this, the basic education of physicians about musculoskeletal conditions is seriously lacking, and it is possible to graduate from medical schools without adequate training in musculoskeletal healthcare. Primary care training programs, more often than not, do not include specific experience with musculoskeletal conditions.

There is a wide range of health professions involved in the management of musculoskeletal conditions. However, in the field of medicine there is a lack of common education between medical specialties, despite integrated **multiprofessional** and **multidisciplinary** care being recommended. Training programs for medical specialties are seldom linked and do not have similar learning objectives, despite often relating to the management of identical problems. In addition, there are few multidisciplinary educational activities at local, national, and international levels that bring together all the relevant disciplines. This is in sharp contrast to the DAC process where it was common practice for health professionals to work in an integrated multidisciplinary setting.

Do physicians have the requisite education, training and experience to provide expert opinions on musculoskeletal conditions? Recent studies have clearly established that most physicians and, in particular, family physicians, do not have the requisite skill, education and training to adequately comment on the broad spectrum of musculoskeletal issues. Medical teaching in musculoskeletal

disorders is currently brief and not directly relevant to the knowledge and skill sets commonly required for management of these conditions in an outpatient setting. Preclinical medical school curriculum devotes less than 3% of its time to the teaching of musculoskeletal injuries and diseases. The subsequent clinical years frequently contain little further training in this area, and the elective programmes available to medical students and interns usually emphasize the surgical management of musculoskeletal problems, which results in a bias towards more severe cases that are not relevant to the future practice of most doctors or the auto insurance arena.

The average medical school training program typically consists of approximately 4667 hours of basic sciences and clinical study over a four year period with a further 2 year family practice residency. In the 1990s in Canada, medical schools offered an average of only 35 hours for teaching musculoskeletal disorders out of 1500 hours of preclinical teaching, 2.33% of the total curriculum, and the subject was obligatory in only 12% of medical schools. By 2001, mandatory musculoskeletal education in Canada declined to 2.26% of the average medical school curriculum and a typical medical school offered only 77 hours of preclinical and 33 hours of clinical musculoskeletal education. Of the sixteen medical schools in Canada at that time, only 5 required exposure to musculoskeletal rotations (orthopaedics, rheumatology and/or rehabilitation medicine).

Since 2001, there has been little change in increasing the number of hours or curriculum. This is a significant and important fact, as it is often these very same physicians, who with less than 100 hours of training, insurers are now relying upon to provide so-called expert opinions.

Studies have shown that graduating family practice residents feel significantly more confident in performing examinations, diagnosing and treating non-musculoskeletal disorders than they do for musculoskeletal conditions. A survey of nearly 400 Australian interns, who underwent a similar medical training program to that offered in Canada, demonstrated an 80% failure rate in assessing disability and handicap in patients with musculoskeletal disorders. Gaps in training translate into suboptimal management practices for primary care physicians dealing with musculoskeletal disorders. Problems with diagnosis, test ordering and medication prescribing have all been documented. A recent survey report published by the American Academy of Orthopaedic Surgeons in 2007, found 51 percent of family practice physicians felt that they had insufficient training in managing musculoskeletal impairments in patients. Furthermore, 56 percent of those surveyed also claimed that medical school was their only source for formal musculoskeletal training.

While these studies demonstrate subjective deficiencies in the quality of musculoskeletal education in medicine, a landmark 1998 study published in *The Journal of Bone and Joint Surgery* demonstrated objective and quantitative deficits. The study involved a simple 25-question musculoskeletal competency survey validated by the chairs of orthopaedic residency programs from across the United States and administered to incoming residents. The results revealed a failure rate of 82 percent and mimics the same result found in the Australian experience. This study concluded that there remains a significant disparity between the number of patients with musculoskeletal conditions who are seen by primary care physicians and the amount of musculoskeletal training these physicians have received. As a result of this disparity, patients with musculoskeletal disorders often received less-than-optimal care. Delayed diagnoses, inappropriate referrals to musculoskeletal specialists, and unnecessary use of therapeutic and diagnostic modalities were common practice, resulting in an increase to the costs of care for these patients. In addition, there were indirect costs, such as lost work days, for these patients who received suboptimal treatment of their musculoskeletal conditions.

There are similar studies demonstrating that many physicians feel they have been inadequately trained to make accurate psychological diagnoses and provide appropriate psychological interventions.

In light of the evidence that many physicians lack the education, training, experience and requisite expertise to conduct thorough musculoskeletal assessments pertaining to benefit disputes and offer expert opinions, many stakeholder groups fail to understand why members of the insurance industry continue to engage in the practice of exclusively using physicians to conduct independent assessments.

As to the issue of expert opinions, the Ontario Government, in June 2006, asked former Associate Chief Justice of Ontario, the Honourable Coulter Osborne, to review and recommend improvements to the civil justice system to make it more accessible and affordable for Ontarians. After widespread consultation, his report was submitted to the Attorney General of Ontario on November 20, 2007. This report is called a Summary of Findings and Recommendations of the Civil Justice Reform Project. The report included recommendations relating to 81 substantive areas of law. The recommendations included changes to the civil court rules for the Superior Court of Justice and the Ontario Court of Appeal (the *Rules of Civil Procedure*). Recommendations were also made to change several statutes, introduce best practices for the legal profession and to improve judicial scheduling practices.

On December 11, 2008, changes to the *Rules of Civil Procedure* were made pursuant to Ontario Regulation 438/08. The regulation was published in the Ontario Gazette on December 27, 2008. Further amendments to the *Rules of Civil Procedure* were made on October 16, 2009 through Ontario Regulation 394/09. While these rules are specific to civil litigation procedures, it is not unreasonable to view their application to all independent assessments, concerning disputed accident benefits,

conducted prior to mediation or arbitration. Certainly, there has been enough precedent set in the era of the DACs, in prior Arbitration decisions and Superior Court decisions to support these new rules at this level of assessment.

On January 1, 2010 the new *Rules of Civil Procedure* came into effect. The changes include reforms to dozens of court rules. The reforms to the expert evidence rules include a new rule which outlines the primary duty of an expert is to assist the Court. An expert is to be fair, objective and non-partisan. **The expert is to provide opinion evidence that is related only to matters that are within the expert's area of expertise**. The expert is to provide such additional assistance as the Court may reasonably require in determining a matter in issue. The expert's duty prevails over any obligation owed by the expert to the party by whom he or she is engaged. An expert must now certify, in the expert's report, that he or she understands this duty to be fair, objective and non-partisan.

The rules have also been amended to require expert reports to include specific information:

- expert's name, address, area of expertise
- instructions provided to expert regarding the proceeding
- expert's qualifications, employment, education
- nature of opinion sought and issue it relates to
- reasons for the opinion (research, assumptions, documents reviewed)

The role of expert witnesses has been well defined previously. In the Supreme Court of Canada case of R. v. Abbey (1982) 2 S.C.R. p. 24, the Court described the role of an expert witness as follows:

> "With respect to matters calling for special knowledge, an expert in the field may draw inferences and state his opinion. An expert's function is precisely this: to provide the judge and jury with a ready-made inference which the judge and jury, due to the technical nature of the facts, are unable to formulate. An expert's opinion is admissible to furnish the court with scientific information which is likely to be outside the experience and knowledge of a judge or jury. If on the proven facts a judge or jury can form their own conclusions without help, then the opinion of the expert is unnecessary."

The admissibility of expert evidence is an exception to the general rule that forbids opinion evidence from witnesses who have no personal knowledge of the facts in issue. Conversely, an expert witness is permitted to testify with respect to inferences or opinions he or she has drawn based on facts that have been proven in the case.

An opinion paper by lawyer Brian Campbell in 2003 stated that expert witnesses are routinely retained by both parties to provide expert evidence which pertains to the subject and/or issues at hand, and to provide opinion evidence which would, but for their expertise be inadmissible. All too frequently the opinion evidence given by experts pertains to the very issues that are before the trier of fact whether it be a judge or a jury. In other words, the Court hears opinions and conclusions from experts which formulates the evidence which in turn determines the outcome of the case.

The leading Supreme Court of Canada case with respect to the determination of the criteria by which to evaluate whether expert evidence is or is not admissible is the case of R. v. Mohan (1994) 2 S.C.R. page 20 which states as follows:

> "Admission of expert evidence depends on the application of the following criteria:
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> (i) relevance;
> (ii) necessity in assisting the trier of fact;
> (iii) the absence of any exclusionary rule;
> (iv) **a properly qualified expert**."

In Mr. Campbell's article, it was his premise that with the proliferation of expert evidence in civil cases in Canada, the Courts should be moving towards a stricter set of rules regarding the admissibility of expert evidence. Counsel, in order to anticipate this phenomenon, should be far more willing to challenge an expert's assumptions and conclusions and deal with the reliability of expert evidence at the outset, rather than allowing the evidence to stand, and then cross-examining on its content.

Mr. Campbell felt that the cross-examination of an expert's qualifications and the challenging of the logical underpinnings of the proposed evidence by litigation counsel are of extreme importance. In his article, he states that the cross-examination of the expert must incorporate not only the substance of his evidence, but areas which deal with its very admissibility. If counsel in Ontario were to adopt the approach which exists in many American states, the courts would at a preliminary stage be confronted with challenges to the proposed evidence which concerned both its admissibility as well as its credibility.

It is up to the trial Judge to determine whether expert opinion evidence will be admissible. This "gatekeeper" responsibility lies at the very heart of the present evidentiary regime governing the admissibility of expert opinion evidence. Accordingly, before an expert will be allowed to give opinion evidence, the witness will be questioned under oath to ensure that he or she has sufficient specialized

knowledge, skill or experience to give the opinion. How the expert has acquired "specialized" knowledge is not always limited to education or practical experience alone. It can come from a combination of such factors as formal education, scientific study, work experience or direct involvement with the subject matter. This process is commonly referred to as "qualifying" the witness. It should be noted that once an expert is qualified, this does not mean they are qualified to testify at future trials.

In an article by lawyer Stacey Stevens (Thomson, Rogers), in 2010, she states that in *Song v. Hong*, Justice Moore was asked to qualify three witnesses all of whom were qualified, trained and experienced in Ontario. Their expert opinions addressed the future care needs of a person who lived and worked in Korea and were informed by hearsay evidence. In ruling whether these witnesses were to be qualified as experts in this particular case, Justice Moore stated as follows: "Even if these witnesses are determined to be experts in a certain field of human activity, their evidence will be led, to the extent that their opinions are not based on personal knowledge, through hypothetical questions. As such, where the factual basis for the opinion is not within the direct knowledge of the witness or did not come to the witness from another expert in the field in a manner that the court may determine to be reasonably reliable, each witness will be asked to assume the facts necessary to support the opinion or opinions of the expert. If there is no evidence upon which the assumed fact may be determined by the jury, it may be that the opinion of the expert will not be heard. If, however, the court is satisfied that there is some evidence before the court now or that may come before the court through the evidence of the remaining witnesses at this trial, the court may allow the jury to hear the opinion of the expert".

Given Justice Moore's comments, Ms. Stevens states that 'rehabilitation professionals who are retained to provide opinion evidence would be well advised to ensure that they have consulted with the appropriate treating health professional during the preparation of their report. This consultation can be accomplished through meeting with the specialist and/or presenting the report for approval by way of a sign back letter'. However, given most physicians' busy schedules, it is unrealistic to think that this will happen.

Having specialized knowledge alone may not be enough in order to be qualified to testify. The Judge will also consider whether the expert or the report bring to the Court an air of bias to one side or the other. The factors taken into account when considering expert bias include:

a) the nature of the expert's stated expertise or special knowledge;

b) any statements the expert has made publicly or in publications regarding the prosecution itself [plaintiff or defendant] or evidencing philosophical hostility toward particular subjects;
c) the expert's history of retainer exclusively or nearly so by the prosecution or the defence;
d) the expert's long association with one lawyer or party;
e) the expert's personal involvement or association with a party;
f) whether a significant percentage of the expert's income is derived from court appearances;
g) the size of the fee for work performed or a fee contingent on the result in the case;
h) lack of a report, a grossly incomplete report, modification or withdrawal of a report without reasonable explanation, a report replete with advocacy and argument;
i) performance in other cases indicating lack of objectivity and impartiality;
j) a history of successful attacks on the witness's evidence;
k) unexplained differing opinions on near identical subject matter in various court appearances or reports;
l) departure from, as opposed to adherence to, any governing ethical guidelines, codes or protocols respecting the expert witness's field of expertise;
m) inaccessibility prior to trial to the opposing party, follow through on instructions designed to achieve a desired result, shoddy experimental work, persistent failure to recognize other explanations or a range of opinion, lack of disclosure respecting the basis for the opinion or procedures undertaken, operating beyond the field of stated expertise, unstated assumptions, work or searches not performed reasonably related to the issue at hand, unsubstantiated opinions, improperly unqualified statements, unclear or no demarcation between fact and opinion, unauthorized breach of the spirit of a witness exclusion order; and
n) expressed conclusions or opinions which do not remotely relate to the available factual foundation or prevailing special knowledge.

The role of an expert witness is also summarized in an article by Owen Smith QC (Journal of the Ontario Insurance Adjusters Association, May 2011). Mr. Smith states that the requirements of Rule 53.03 now makes it incumbent upon experts seeking to give evidence to certify that they understand and will observe a duty to be objective and impartial and has called into question the ability of accident benefits doctors to offer their evidence in a trial.

In *Beasley et al. v. Barrand* (2010 ONSC 2095), the Court denied the insurer's motion to: (a) file medical expert reports that were used in the Statutory Accident Benefits claim, and (b) call the doctors who authored those reports as experts at trial. Each physician had only seen the plaintiff on one occasion approximately seven years prior to the trial. The Court held that noncompliance by the defence with

the newly enacted Rule 53.03 was fatal to its motion. Rule 53.03 (2.1) enumerates the content that is now required in an expert's report.

However, in April 2011, the Court in *McNeill v. Filthaut* disagreed with the decision in *Beasley* and held that Rule 53.03 does not apply to experts engaged by non-parties to litigation, namely, accident benefit assessors (2011 ONSC 2165 at para. 44). The Court held that Rule 4.1.01, Rule 53.03, and Form 53 provide a comprehensive framework for dealing with expert witnesses at trial and that the requirements of Rule 53.03 were intended to and should only apply to experts that are engaged by or on behalf of a **party**. The Court found that DAC assessors were bound by guidelines that afforded the plaintiff a strict duty of neutrality and objectivity, and as such were not the "hired guns" that Rule 53.03 is intended to curtail.

Mr. Smith states that “the old days of when an adjuster or claims person retained an expert to offer opinions on liability and even damages are now gone. Now a team approach is required to examine the substantive issues to be commented on by the expert and whether or not he or she can offer an opinion that will be accepted by the courts. Experts and their testimony are now being scrutinized by judges who accept their duty to act as gatekeepers and to exclude any evidence that may be deemed as less than impartial or competent. The days of the ‘*for hire’* or ‘*cheer leader’* experts are history. Many experts overstep the boundaries of what they are qualified to opine about”.

Similarly, in Ms. Stevens paper, she states that “at the end of the day, it is clear that the amendments flowing from the Civil Justice Reform Project reflect the Court’s requirement that experts ***be and appear to be independent of the party and counsel who retained the services of the expert*** **and** ***demonstrate objectivity and impartiality in the analysis and opinions that he or she is allowed to give***. Whatever role the expert has undertaken in order to assist counsel in drawing a fuller appreciation of the disputed facts and possible inferences, the expert must set aside this role at trial and remain independent and impartial as ***the court expects nothing more and will accept nothing less****.”*

Again, while these rules are specific to court cases, it is not an unreasonable expectation that they apply to all independent examinations as the current environment in auto insurance encourages the movement of dispute resolution to Mediation and Arbitration where they are applicable.

As a part of the auto insurance dispute resolution process, the mandate of FSCO’s Dispute Resolution Services Branch (DRSB) is to provide timely, cost-effective and fair dispute resolution services for resolving disputes between consumers and insurers involving benefit claims under the Insurance Act and the Statutory Accident Benefits Schedule.

The DRSB provides these services through a continuum of processes which include mediation, arbitration and appeals. Mediation is a legislated, mandatory first step. Neither party can proceed to arbitration, court or neutral evaluation unless mediation has been sought and mediation failed.

FSCO has published timelines for processing mediation applications in the Dispute Resolution Practice Code (DRPC). The DRPC provides that an Application for Mediation will be assigned to a mediator within three weeks of it being deemed a completed application. The DRPC also provides that mediation will be conducted within the legislated time frame of 60 days, following assignment to a mediator or within the time extended by the agreement of the parties. A “Report of Mediator” being issued at the conclusion of the mediation.

Since the demise of the DAC system in 2006, there has been a steady rise in the number of applications for Mediation at FSCO. These increases were accurately predicted in an Actuarial Report commissioned by the Association of Designated Assessment Centres from the firm Ernst and Young in 2005. Due to the increase in the volume of applications received over the past few years, a significant backlog of files has developed. While a number of steps were taken and initiatives were put into place to help deal with this situation, these measures have failed to fully address the problem. The current pressure of increasing applications for mediation and eventually arbitrations is expected to continue long-term.
An arbitrator at the Financial Services Commission of Ontario (FSCO) is recently quoted as saying that resolving auto accident benefits claims disputes "on a timely basis" has become "an increasingly critical issue" in the province's alternate dispute resolution (ADR) system.

In his decision in *Dominion of Canada General Insurance Company* and *Jaswinder Singh*, FSCO Director Delegate Lawrence Blackman cited FSCO statistics that showed "a fourfold increase from 2007 to 2010 in mediation cases to some 14,000 pending mediation files.”

With the introduction of new auto insurance regulations in September 2010, the applications for mediation have, at the beginning of June 2011, jumped from an already unacceptable level of 14,000 cases to a staggering number of over 28,000 files with more than a nine month delay in FSCO’s acknowledgement and processing of just the first stage of the dispute resolution process. The rise in applications is partially due to some insurers bypassing the independent assessment process and proceeding immediately to mediation. It is further anticipated the mediation numbers will continue to rise as more accident victims are encouraged to apply for this dispute resolution process when benefits are denied as a consequence of independent assessments being conducted by unqualified mythical doctors.

Unacceptable FSCO Mediation and Arbitration statistics from 2005 serve to highlight the failure of auto insurance reforms since 2003 and these numbers are reportedly worsening. This failure is further evidenced by the rise in independent assessment costs from $53 million per year in the DAC era to over $400 million in 2010.

FSCO Mediation Statistics (2005)	
Average time from date of accident to the date an application for mediation received	568 days
Average time from date of application received by FSCO to date of mediation	97 days
Full resolution of mediated cases	37%

FSCO Arbitration Statistics (2005)	
Average time from date of accident to the date an application for Arbitration received from FSCO	747 days
Average time from date of application received by FSCO to date of arbitration report	692 days

Since 2006, with the influx of new Mediation and Arbitration claims, timelines are being further stretched and it is only a matter of time before auto insurance will have fully reverted "Back to the Future" of a pre-OMPP era of duelling opinions with its significant potential to recreate the financial crisis that existed in the auto insurance industry in the late 1980s with insurers once again calling for additional reforms of the system that will further deny appropriate and timely benefits to legitimate accident victims.

The Ontario Automobile Insurance regulatory system has undergone significant change over the last 15 to 20 years. The changes have not always been progressive. The current existing legislation and regulations have failed to meet the needs of ratepayers and legitimate accident victims and, in particular, the more seriously injured. The current growing backlog of applications for mediation, which is a legislated, mandatory first step in the dispute resolution process, forebears that further necessary changes will be required to ensure cost stability for ratepayers, while still guaranteeing appropriate access to needed goods and services for legitimate accident victims. Legislative and regulatory changes must take into consideration the need to ensure that there is timely access to qualified (through education, training and experience), neutral, expert opinions to address benefit issues and that these opinions provide appropriate, evidence-based, recommendations to help prevent an overburdening of the mediation and arbitration processes and other dispute resolution systems.