

Independent Medical Examinations

Implications of Unfair IMEs and Consumer Complaints

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The personal injury dispute resolution process depends on all players in the process acting in good faith. If one or two of the institutional players decides not to play by the rules, then the whole process becomes tarnished and the public's confidence in the process is greatly diminished.

We believe that everyone involved in a contract dispute for health care or income support benefits in Canada has an obligation to act in good faith. That obligation extends to all the lawyers, the healthcare providers, the case managers, the adjusters and, most importantly the insurance medical doctor. Of all of the players in these cases, the insurance medical doctor is probably the one individual who should be held to the highest standard. The reason for that is because the insurance doctor gives the court the medical database upon which the adjuster makes a decision. The adjuster's decision, in many cases, is really based on the insurance doctor's report as to eligibility for benefits. The insurance doctor's work is therefore at the very foundation of the case. If that work is suspect or dishonest then the whole process that flows from that work is tainted with dishonesty, if the adjuster is not intelligent enough to understand or distinguish between an honest and a dishonest medical approach then the adjuster, in a sense, has been duped.

However, the decision to use certain medical doctors is not made by the adjuster but is controlled at most insurance companies by the management who have "preferred lists" of doctors who have agreed to provide services to the insurance company on certain conditions. A doctor who makes a living selling these opinions to insurance companies soon becomes very much aware of the fact that if he terminates more benefits than he accepts, he will get lots of repeat business.

It is unusual to have an insurance doctor approve benefits in the great majority of cases. That just doesn't happen. The insurance company just doesn't use them anymore. Therefore, the system of reward is designed to ensure that doctors who are willing to bend the facts or be a little more aggressive in denial of benefits, do. In fact, they will receive the overwhelming number of referrals for assessments. It is not unusual for physicians to be making half a million dollars in fees doing this work full-time.

Accordingly, if one were to look at the very underpinning of the system one has to realize that a dishonest insurance doctor can and does corrupt the whole process. In the past, however, the dishonest insurance doctor was able to act as an advocate and had the shielding of the court to protect him or her. In a lawsuit on a tort basis - that is, where you're suing someone else for negligence - the insurance doctor is called a "defense medical" and that is triggered under the Rules of Practice. The

Rules of Practice and the court process protect the expert witness from lawsuit or accountability to anyone but the judge in the case. The unfairness of that rule is that insurance doctors get aggressive and they know that in 98% of cases policyholders will settle the case. So the insurance doctor is never held accountable for the defense medical opinion. This has allowed many defense medical doctors to give opinions that are clearly and outrageously one-sided and are, in fact, advocacy with impunity. They know that the odds against being cross-examined for the report are against the duplicity of the report ever coming to light. In other words, a defense medical doctor soon learns that his report is not likely to be scrutinized by a cross examination or by a judge in clearly 98 out of 100 cases and the insurance doctor then starts to play the odds. The more aggressive the report the more referrals he gets. The more aggressive the report the better known he is in the industry. If he does 250 reports a year then the risk is that only five will ever get into a courtroom and then the risk of ever having to face cross-examination is even lower.

As you can see, the rule protecting the defense doctor encourages bad behaviour and dishonesty and there are approximately 25 or 30 "famous" insurance doctors in the province who have worked this system very well.

That is the tort system and it's protected by the Rules of Negligence where the parties have no obligation to each other unless a court finds those obligations in negligence.

However, where there is a contract of insurance between the policyholder and the insurance company, as is the case in disability insurance or automobile insurance, the obligation between the insurance company and the policyholder is one of good faith. There is case law that suggests that the obligation to act in good faith also extends to the insurance medical examiner in performing his or her duties as an ME under either a disability policy or an automobile policy. The theory developed in those cases both at the Financial Services Commission of Ontario arbitration system and in the court system relies on the concept of the healthcare triangle. That is the cooperation between the service provider, the insurance company and the policyholder. That relationship is clothed in good faith and the good faith obligation extends to all who have a role to play in the insurance contract as agents of the insurance company and/or the policyholder. Accordingly, an insurance doctor has an obligation to act in good faith and is not shielded for a lawsuit against him or her for failing to act in good faith, in fact, the Rules of Practice shield the expert as mentioned above. No such shield exists for the insurance Medical Examiner under Accident Benefits or Disability Claims processes. In fact, the latest amendments to the Automobile Insurance Policy clearly states that a DAC may be sued if it acts in bad faith but not otherwise.

By carving out the exception it appears the legislature is telling us that insurance doctors should be subject to the rules of good faith much like the adjusters and the insurance companies and the policy holders.

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What are the implications of the rule?

In the long run the culture of Accident Benefits and Disability Claims will change dramatically. At this point there is very little perceived accountability on the part of insurance doctors. I have, however, been part of proceedings where they've expressed serious concerns about being sued in bad faith and that has come to the point where one major insurance company is marketing an insurance policy in the event the insurance doctor does get sued in bad faith. The recognition of an insurable interest leads me to believe that the culture has developed to the point where the insurance doctor now understands there may be exposure for his opinion if it's perceived to be acting in bad faith.

Disability carriers normally don't hire outside insurance Medical Examiners. Where they do, obviously, those doctors must act in good faith and have a balanced scientific approach to the analysis that they undertake. That would include not narrowing the scope of inquiry to the point where the questions asked are irrelevant to the disability displayed. For example, if you have a psychological problem that results in severe depression it would be bad faith on the part of a doctor to simply do a musculoskeletal assessment and pronounce you fit for work. On the other hand, if you have a very serious disc protrusion in the lower back it would be bad faith for a psychologist to say that you're ready to go back to work because there's nothing wrong with you from a psychological point of view.

The assessment protocols need to be holistic in their approach and must take the whole person into account. The recent adoption of the 55% impairment of the whole person standard in the automobile policy is leading in that direction. In other words, no longer can the insurance doctor take a "meat chart" approach and determine disability on the basis of the functioning of a hand or a wrist and ignore the very real consequences of a serious injury not only on the person's social life but home life as well as work life. The automobile policy requires that physicians look at reintegration of the policyholder into home society and work and the old way of looking at these injuries has been discarded by the legislation.

The problem we have in Ontario is that most of our insurance doctors have been trained in occupational medicine and they are still using the old-fashioned Worker's Compensation meat chart approach to determining disability. That's a very safe place for them to be because it allows them to be dishonest about the whole person and simply focus on the orthopaedic or the psychological issue without connecting the dots to give us and the court the whole picture.

Accordingly, it is the obligation of the insurance doctor to do good medicine and that includes being able to go across systems and deal with the whole person as opposed to an arm or a leg. That obligation is clearly based on a scientific analysis of the functioning of the organism which, after all, is the true definition of disability.

This is now becoming more an accepted standard. For example, Revenue Canada was recently criticized for denying that a person who has trouble preparing meals is disabled. Previously the definition of the inability to feed oneself meant that the person could not take the spoon to the mouth. Recent opinion says that the ability to prepare meals and be organized to shop for meals and to attend to meal preparation is really the true definition of being able to feed yourself and the silly proposal that if you're able to put a spoon to your mouth then you're able to feed yourself has been discredited.

It's this kind of fuzzy thinking that has infected the process in the past and it's really designed to allow low-level analysis by adjusters who can then avoid having to make judgments based on science.

If an insurance company routinely hires dishonest insurance doctors then it can be said they have a conscious claims practice they put into the process to cheat the policyholder. There are many cases where that happens and have been demonstrated as being part of standard operating procedure. A movie that clearly outlines the problem is called *Damaged Healthcare*, it's a recent release by Paramount Pictures and is now in the video store and would be well worth the view by all your members. It clearly outlines the dilemma faced by some in-house physicians and how the culture of denial is programmed into the insurance decision-making process.

What can a consumer do?

In the past, consumers have been limited as to their right of free expression. Libel and slander laws have been used, or abused, by powerful organizations to stifle dissent and comment by consumers. That is now a thing of the past. An honest opinion as to the quality of the service received by a consumer is no longer part of the libel and slander regime and now falls into the category of counter-advertising or consumers' free speech.

The *Guignard* case is a potentially more important decision than the *Whiten* case because it does, for the first time, recognize in very clear and articulate language the consumers' dilemma in dealing with large organizations. The case stands for the proposition that organized consumer protest on poor service or bad quality service or bad claims practices are something that should be encouraged. The court goes on to say that opinions held in good faith and with some reasonable basis for holding them is protected under our constitution as the flip side to the commercial free speech provisions that have been with us for many, many years.

This opens the door to protests by sign-carrying policyholders that march up and down the head office of a major insurance company by 10 or 15 dissatisfied "customers". If the complaint is poor service they are allowed to walk up and down the street with placards declaring they have found the service to be poor and to warn

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other consumers about the same problem. Additionally, websites will start being developed about poor service companies. The American Internet experience is very advanced in this regard and if one types in Allstate you'll see that there are probably five or six websites that have criticism of the claims processes that Allstate uses generally in North America. These websites are specifically mentioned in the Guignard case as a practical way of conveying information between consumers.

In the past, because each individual claim was handled as a separate claim, consumers were divided and left alone to fight their own battles. Guignard, on the other hand, allows them to link together, to share information, to arrive at a consensus and to plan a course of conduct together. That is designed to bring to the attention of the public that a certain insurance company, for example, delivers poor service or is insensitive to claims or demonstrates a habit of denying claims and forcing the policyholder to fight for the claims in a soft tissue case, (For example, we have an admission under oath in one of our cases that the insurance company adjuster was instructed to refer all soft tissue cases on to the denial stream as a matter of corporate policy. That, in spite of the fact that treating physicians and other service providers found the disability to exist.)

The Guignard decision therefore gives the consumer the opportunity to have the same impact on the insurance industry that the consumer protests of the '70s brought to bear on the environment and the auto industry and all of the other consumer movements that have now been institutionalized by legislation. The protests against damaging the environment have found their way into legislated environmental code and now it's become a worldwide treaty known as the Kyoto treaty. That treaty really had its genesis in the early protests by environmentalists who, in those days, were considered a bit crazy for their tree-hugging notions. Similarly the protests on the quality of vehicles and vehicle design have also found their way into legislation and most consumer protests ultimately lead to legislative responses and the changing of behaviour.

The insurance consumer's most powerful tool is to expose the poor service of the insurance company to the general public at large. The reason it's powerful is because insurance companies are generally not used to dealing with being accused of bad service. They have a legislated product. They have a monopoly of sorts because they know the market share is always going to be there for them. Consumers have no option but to buy insurance. Most insurance companies have fallen into a quietly collaborative poor service culture where everyone sinks to the lowest common denominator. There is very little competition for good service. In fact most insurance companies compete on the basis of price. Recent advertisements by insurance companies are starting to push the service issue as a way of competing and finding customers; however, the service commitment is not yet put into practice.

Your organization would go a long way in moving the insurance consumer movement forward by organizing silent protests at Queen's Park and in front of head offices of major insurance corporations who routinely are the subject of complaints by your members. I would think that this extra institutional tool will likely be seen as one of your more powerful ways to change behaviour at the corporate level. Shareholders do not want to see the head office of their company picketed by 10 or 15 people and accusing that company of acting unfairly or delivering poor service. That has a significant marketplace reaction and it will change corporate behaviour much faster than any court system ever can hope to do.

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