IE CONSENT FORMS:
NOT SO SIMPLE AS "SURE, WHERE DO I SIGN?"

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Canadian Defence Lawyers Annual Accident Benefits Symposium
April 25, 2013

INTRODUCTION

Clashes arising over the use of Consent Forms in insurer examinations ("IEs") are an increasing phenomenon. Often, neither the insurer nor the insured receives any prior warning from an IE examiner and/or assessment centre that a signed Consent Form will be required at the IE in order for it to proceed. A common scenario occurs when an insured attends an IE willing to participate but refuses to sign the Consent Form that she has not had an opportunity to review with her counsel. The examiner then refuses to conduct the IE and the timely adjustment of benefits is stalled.

This paper will address three questions:

1. Is an insured *required* to sign a Consent Form?
2. What in the Consent Forms is causing all of the fuss?
3. What are the consequences of failing to resolve the Consent Form dispute in advance of the IE?

IS AN INSURED *REQUIRED* TO SIGN A CONSENT FORM?

i. Is an insured required to sign a Consent Form under the *SABS?*

The singularly most important premise from which to commence the discussion about IE Consent Forms is that there is no express or implied provision under the *Statutory Accident Benefits Schedule – Effective September 1, 2010*[1] that requires an insured to sign a Consent Form.

Section 44 of the *SABS* is an exhaustive rule that governs the process for IEs. This section is absolutely silent on any reference to a Consent Form, let alone a mandatory requirement that one be signed.

Not only is there no express requirement under the *SABS*, no other section of the *SABS* implies that a signed Consent Form need be signed.

Conversely, section 44(9)(2), confirms that consent is implicit in the insured's attendance at the IE. It states:

> If the attendance of the insured person is required,
>
> …
>
> (iii) the insured person shall attend the examination and submit to all reasonable physical, psychological, mental and functional examinations requested by the person or persons conducting the examination.

[1] O. Reg. 34/10 [*SABS*].

Section 66 also suggests that there is no support in the *SABS* for requiring a signed Consent Form. Section 66 provides that (virtually) all insurance forms (notices, disability certificates, etc.) must be in a form approved by the Superintendent.

Arguably, one of the purposes underlying section 66 is the ever-cited "consumer-protection". Section 66 is a means of quality control to ensure that in an otherwise complicated insurance regime, forms that are sent to insureds can be easily understood by them and are consistent with their rights and obligations under the *SABS*. The simplicity and consistency of insurance forms is all the more crucial considering that many insureds form part of a vulnerable population (e.g. brain injuries, psychiatric disorders, English as a second language, etc.). Permitting numerous different types of Consent Forms to be distributed to insureds would run counter to the consumer-protection foundation of the *SABS.*

ii. Is an insured required to sign a Consent Form at common law?

To date, the issue of signing Consent Forms has mainly arisen in the tort context of defence medical examinations.

In the decision of *Chapell v. Marshall Estate*[2], the Plaintiff was ordered to undergo a further defence medical examination. He attended, but refused to sign the Consent Form presented to him. Valin J. stated[3]:

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[2] [2001] O.J. No. 3009 [*Chapell*].
[3] *Ibid.* at paras. 21-23.

> …There is no requirement in s. 105 of the [*Courts of Justice Act*] or in rule 33 of the *Rules of Civil Procedure* requiring an injured plaintiff to sign an authorization, consent or agreement when attending a defence medical examination ordered pursuant to s. 105 of the Act.
>
> There appears to be a misunderstanding of the role of the examining doctor or other health practitioner. In conducting a defence medical examination, a doctor or other health practitioner is not operating within the bounds of the traditional doctor-patient relationship where the doctor has been engaged by the patient whose trust and confidence in the doctor are essential to their relation. Instead, the defence medical examination takes place in the context of an ongoing legal dispute where the examinee's adversary has retained the examining health practitioner. The examining health practitioner is not subject to the usual confidentiality requirements which are essential to the doctor-patient relationship. Indeed, the examining health practitioner's very purpose is to report his/her findings to the examinee's adversary…
>
> …Stated another way, she is entitled to refuse to sign any authorization, consent or agreement presented to her by an examining health practitioner in those circumstances.

In *Tanguay v. Brouse*[4], also decided by Valin J., the defence medical examination was not Court-ordered (a point raised by the defence in an effort to distinguish the circumstances from *Chapell*). Nevertheless, the same conclusion was reached. Valin J. stated:

> I am of the view that s. 105 of the *Courts of Justice Act* and Rule 33 contain a complete code and procedure for court ordered medical examinations in Ontario. Neither s. 105 of the Act nor Rule 33 contain a requirement that the party being examined execute any consent, authorization or agreement presented by an examining health practitioner in advance of or during an examination.
>
> …
>
> In *Bellamy v. Johnson*, Doherty J.A. makes the distinction in roles between that of a doctor conducting a defence medical assessment under s. 105 of the *Courts of Justice Act* and a doctor examining a patient within the bounds of the traditional doctor-patient relationship. That distinction

[4] [2002] O.J. No. 4711 [*Tanguay*].

> lies at the core of this decision. In my view, a medical examination conducted under s. 105 of the *Courts of Justice Act* and Rule 33 enables a health practitioner in Ontario to (a) carry out the examination and (b) report his/her findings to the adversary of the party examined without fear of successful prosecution for professional misconduct based on the absence of written consent to do either or both of (a) and (b).

The only recent FSCO case to address the issue of Consent Forms in the context of *SABS* IEs is the decision of Arbitrator John Wilson in *Luther v. Economical Mutual Insurance Company*.[5] In *Luther,* the insured had been injured in an accident that took place on May 28, 2007 (i.e. pre-September 2010). When an IE was arranged, the insured attended and expressly consented to participate. He refused, however, upon the advice of his counsel, to sign the Consent Form (primarily due to the fact that it contained a disclaimer clause). The examiner refused to proceed with the IE. The specific issue before Arbitrator Wilson was whether Mr. Luther's failure to sign the Consent Form amounted to a "failure to attend" the IE, such that the insurer could refuse to pay his benefits.

Although Arbitrator Wilson ultimately held that in the particular facts of the case the insured could not be considered to have "failed to attend" the IE, he was not prepared to make a broad declaration that Consent Forms were not required in the IE context. His rationale was based on what he perceived to be a key distinction between tort defence medical examinations and *SABS* IEs. He stated:[6]

> Section 42 examinations took (*sic*) place in the context of a first-party scheme in which the examination is in aid of the determination of benefits in situations where for the most part there is no presumption of an adversary relationship. Section 105 examinations are specifically

[5] (2012), FSCO A10-003773 [*Luther*].
[6] *Ibid.* at 10-11.

> contingent on there being a dispute before the courts where some aspect of the health of an individual has been put into question.
>
> …
>
> Given the differing characteristics and goals of section 42 examinations and those under the *Courts of Justice Act*, I do not accept that it is obvious that Valin J.'s approach must apply without modification to section 42 examinations. I note that both *Chapell* and *Tanguay* deal with orders to be examined. In such cases, the rationale of no consent makes sense. Lack of consent does not invalidate such a mandatory order.
>
> …In the absence of a specific clause in the *Schedule* outlining the responsibilities of examiners, or of a court order mandating an examination, I accept that it is reasonable for an examiner to ask for a generalized consent before undertaking a section 42 examination and to document that process. Consequently, I am unwilling to make any broad declaration that *Chapell v. Marshall Estate* and *Tanguay v. Brouse* govern the issue of consent in all section 42 examinations.

There are two key points to highlight from the *Luther* decision:

1. Arbitrator Wilson seems to have taken it for granted that relevant healthcare legislation had no application to IMEs, such that he decided the issue with guidance only from common law principles.
    a. *As will be shown in this paper, there is reason to believe that this presumption was incorrect and, in fact, healthcare legislation does apply.*

2. Although Arbitrator Wilson confirms that it is reasonable to require that consent be obtained and documented, he does not state that it must be documented in the manner of a signed Consent Form.

    a. *As will be shown in this paper, most health care practitioner colleges believe that it is sufficient to simply record in the clinical notes or report that consent was obtained.*

iii. Is an insured required to sign a Consent Form under relevant healthcare legislation?

As Arbitrator Wilson pointed out in *Luther*, the topic of consent is addressed in the *Health Care Consent Act, 1996*.[7] The *HCCA* does not use the words "evaluations" or "assessments"; however, it does speak to "treatment" that is provided by "evaluators". A closer look at these latter terms suggests that the *HCCA* would apply to most IEs.

First, the term "evaluator" in defined in section 2 of the *HCCA* as follows:

> …means, in the circumstances prescribed by the regulations,
>
> (a) a member of the College of Audiologists and Speech-Language Pathologists of Ontario,
>
> (b) a member of the College of Dietitians of Ontario,
>
> (c) a member of the College of Nurses of Ontario,
>
> (d) a member of the College of Occupational Therapists of Ontario,
>
> (e) a member of the College of Physicians and Surgeons of Ontario,
>
> (f) a member of the College of Physiotherapists of Ontario,
>
> (g) a member of the College of Psychologists of Ontario, or
>
> (h) a member of a category of persons prescribed by the regulations as evaluators.

With regards to subsection (h), the regulations[8] prescribe social workers to be evaluators as well.

[7] S.O. 1996, c. 2, Sch. A [*HCCA*].
[8] O. Reg. 104/96.

Notably absent from the list of "evaluators" are: dentists, vocational rehabilitation experts, massage therapists, and kinesiologists. Presumably, the *HCCA* would have no application to IEs conducted by these four types of experts.

Second, the term "treatment" is defined in section 2 of the *HCCA* as follows:

> …anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other health-related purpose, and includes a course of treatment, plan of treatment or community treatment plan, but does not include,
>
> > (a) the assessment for the purpose of this Act of a person's capacity with respect to a treatment, admission to a care facility or a personal assistance service, the assessment for the purpose of the Substitute Decisions Act, 1992 of a person's capacity to manage property or a person's capacity for personal care, or the assessment of a person's capacity for any other purpose,
> >
> > (b) the assessment or examination of a person to determine the general nature of the person's condition,
> >
> > (c) the taking of a person's health history,
> >
> > (d) the communication of an assessment or diagnosis,
> >
> > (e) the admission of a person to a hospital or other facility,
> >
> > (f) a personal assistance service,
> >
> > (g) a treatment that in the circumstances poses little or no risk of harm to the person,
> >
> > (h) anything prescribed by the regulations as not constituting treatment.

Finally, section 3(2) of the *HCCA* provides:

> If a health practitioner decides to proceed as if an excluded act were a treatment for the purpose of this Act, this Act and the regulations apply as if the excluded act were a treatment within the meaning of this Act.

Based on the exclusion in subsection (h), "the assessment or examination of a person to determine the general nature of the person's condition", Arbitrator Wilson concluded that IEs did not fall under the term "treatment". He reached this conclusion, however, without providing any analysis or reasoning. He simply stated:

> Thus, according to the *HCCA*, an assessment or examination does not require compliance with the consent rules under the Act unless the health practitioner proceeds as if the Act applied.

While Arbitrator Wilson *may* be correct in his presumption, there is an argument to be made that he was not. Recall that the term "treatment" was specifically defined to include "*anything* that is done" for (amongst other things):

- diagnostic purposes;
- other health-related purposes; and/or
- a plan of treatment.

The fact is that most IE reports include consideration of (if not focus on) the insured's diagnosis and the extent to which it is accident-related; determining whether a particular treatment, device, or therapy would be of benefit to the insured; and/or proposing further treatment recommendations. As such, at the very least, the question of whether an IE could be considered "treatment" under the *HCCA* is equivocal.

Section 10 of the *HCCA* does require that an evaluator obtain consent before providing treatment (there are separate provisions that deal with emergency treatment); however, this section does not state that the consent must be obtained in writing and/or via a signed Consent Form.

If it is assumed for the moment that the *HCCA* can apply to IEs (those conducted by "evaluators"), then the answer to the Consent Form issue is resolved. The *HCCA* does not require that consent be obtained in writing.

Similarly, section 11 of the *HCCA* sets out the elements to informed consent. Again, nowhere does it state that the consent must be obtained in writing and/or via a signed Consent Form. To the contrary, subsection 11(4) confirms that "the consent to treatment may be express or implied."

iv. Is an insured required to sign a Consent Form under regulatory policies, procedures, or guidelines?

Regulatory colleges will often circulate practice directions, policies, procedures, or guidelines to assist their members in understanding the approach to otherwise tricky legal and practical issues. Many of the health care practitioner colleges have disseminated documents specifically addressing the matter of consent. In doing so, the professional colleges have largely deferred to the *HCCA* and confirmed that consent need not be obtained in writing.

By way of illustration, three regulatory guidelines are reviewed below:

1. The College of Nurses of Ontario initially drafted a practice guideline entitled "Consent"[9] following the enactment of the *HCCA*. The guideline has since been revised over the years. It states: "Informed consent does not always need to be written, but can be oral or implied."

2. The College of Occupational Therapists of Ontario ("COTA") released its own document in September 1996 entitled "A Guide to the Health Care Consent and Substitute Decisions Legislation for Occupational Therapists."[10] It states:

> As stated earlier, consent can be written or oral. In most circumstances verbal consent for occupational therapy treatment is sufficient. The occupational therapist is advised to indicate within regular record keeping practices that informed consent was obtained or acknowledged. Where informed consent is not secured, or where consent is withdrawn it is recommended that the occupational therapist record the details of the events leading to the lack of consent.
>
> Occupational therapists are urged to consider those activities within their practice that may be considered areas where potential risk of harm to an individual is evident (e.g. home visit, splint). In such circumstances a written consent from may be of value. A sample has been included as Appendix C for your reference. It is important to keep in mind that a signed form is not singular evidence that informed consent occurred; informed consent as outlined in this section is a process of understanding, not a signed document.

[9] College of Nurses of Ontario, Practice Direction, "Consent" (2009).
[10] College of Occupational Therapists of Ontario, Practice Direction, "A Guide to the Health Care Consent and Substitute Decisions Legislation for Occupational Therapists" (September 1996).

3. The College of Physicians and Surgeons of Ontario ("CPSO") also addressed the issue of consent in Policy Statement 4-05.[11] The policy states:

> Although the [*HCCA*] contains exceptions to the definition of "treatment", the College advises physicians to obtain consent for all physician-patient interactions. For many of these interactions, a physician will be able to rely on implied consent.
>
> …
>
> Although the [*HCCA*] states that consent to treatment may be express or implied, physicians are strongly advised to obtain express consent from the patient.
>
> Physicians should be aware that the critical element of the consent process is the information given to the patient by the physician. Signed consent forms are simply documentary confirmation that the consent process has been followed, and the patient has agreed to the proposed treatment. Physicians are advised to note in the patient's record that consent has been obtained by noting what went into the decision-making process. Likewise, physicians should note in the patient's medical record if the patient has refused consent and the discussion that took place.

Although the above CPSO policy deals with consent, generally, the CPSO has also released two policies that deal with consent specifically in the context of medical examinations conducted at the behest of a third party. While both policies support documenting consent, neither *requires* that the examinee *sign* a Consent Form.

First, the CPSO policy entitled "Third Party Reports: Reports by Treating Physicians and Independent Medical Examiners"[12] states:

[11] College of Physicians and Surgeons of Ontario, Policy Statement 4-05, "Consent to Medical Treatment" (January/February 2006).

> Physicians must obtain the patient's or examinee's consent for disclosing personal health information to the third party and for conducting a medical examination. The College strongly advises physicians to document that consent has been obtained.

In other words, a) written consent is still not *mandatory*; and b) it is encouraged only to be "documented". "Documenting" does not require the signature of the examinee, it can simply be a recording in the clinical notes or the report that consent was obtained.

Second, the CPSO policy entitled "Medical Expert: Reports and Testimony"[13] discusses that consent must be obtained, but does address the manner in which it must be obtained.

It should be noted that there are some organizations of health care professionals who prepare their own guidelines as to the approach to consent in the context of third party examinations. These organizations, however, have no authority. Take, for instance, the Canadian Academy of Psychologists in Disability Assessment ("CAPDA"). The CAPDA is neither a regulatory nor governing body; it is simply an organized group of psychologists. The CAPDA "Practice Standards for the Psychological Assessment of Disability and Impairment"[14] state:

> The standards outlined below are practice standards. They do not replace those ethical standards, or conduct regulations, standards or guidelines endorsed by provincial regulatory bodies…

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[12] College of Physicians and Surgeons of Ontario, Policy Statement 2-12, "Third Party Reports: Reports by Treating Physicians and Independent Medical Examiners", (May 2012).
[13] College of Physicians and Surgeons of Ontario, Policy Statement 7-12, "Medical Expert Reports and Testimony", (December 2012).
[14] Canadian Academy of Psychologists in Disability Assessment, "Practice Standards for the Psychological Assessment of Disability and Impairment", (May 2004).

> Psychological assessors of disability shall acquire (*sic*) a witnessed and signed consent by the individual client or the legal guardian or representative to proceed with a disability assessment unless otherwise required by a provincial regulation or statute.

#2: WHAT IN THE CONSENT FORMS IS CAUSING ALL THE FUSS?

Part of the fuss over Consent Forms is the suggestion of a requirement that they must be signed; however, a bigger issue is that many of the Consent Forms go far beyond what may be considered appropriate for purposes of an IE.

By way of example, recall that COTA does not insist or even recommend that occupational therapists have patients sign a Consent Form. If one is going to be signed, however, the sample COTA Consent Form (**Appendix A**) is relatively simple. It simply asks the patient to confirm that she has been told about:

- what the treatment is;
- who will be providing the treatment;
- the reasons for having the treatment;
- the alternatives to having the treatment;
- the important effects, risks, and side-effects; and
- what would happen if she did not have the treatment.

Even if some of those headings would not necessarily apply to IEs, the point is that each heading is presented in a short, straight-forward manner, and does not go beyond what is reasonably required for informed consent to the treatment.

Contrast the COTA sample Consent Form to those frequently being seen in IEs, where the Consent Forms:

- include a disclaimer clause releasing the IE examiner and/or assessment centre from liability arising from injuries arising in certain circumstances during the course of the IE;

- are pro forma and/or overly broad, such that they refer to a purpose of the assessment that is beyond that which was set out in the OCF-25 sent to the insured (e.g. a reference to a housekeeping assessment when the insured is not even entitled to housekeeping benefits by virtue of being non-catastrophic);

- are unduly complicated with many premises to which the insured must agree, in language that may be difficult for the insured to understand;

- include blank spaces for additional information, instructions, or otherwise which could be completed by the IME examiner *after* the Consent Form has already been signed;

- permit the disclosure of the insured's personal information and test results far beyond what is appropriate for the IME.

Consider the following two "real life" case studies which illustrate the problems that can arise with Consent Forms:

Case Study #1

- An IE with an occupational therapist was scheduled to determine the reasonableness of an OCF-18 for a gym membership.

- Six days prior to the IE, the assessment centre sent the insured's counsel a copy of a Consent Form (**Appendix B**) that the insured would be required to sign at the IE.

- Given that IE was over a gym membership, some concerns with the Consent Form included the facts that it:

  - was a full page in length, with 11 separate paragraphs;

  - asked the insured to agree that an Assessment of Attendant Care Needs (From 1) was to be completed;

  - asked the insured to agree that the consultant explained her/his role in this process and that her/his scope of practice includes the assessment/treatment of functional activities (for example: personal care, homemaking and home maintenance, care-giving…);

  - included a blank space that indicated "the consultant may attempt to communicate with __________________ should further information be required in order to provide an opinion as to the reasonability and necessity of the proposed Treatment and Assessment Plan (OCF-18)" without any indication as to whom the consultant intended to consult or confirmation that this blank space would not be filled in by the IME examiner after the Consent Form was already signed.

    - *Note: The question of whether it is even proper for an IME examiner to consult with corroborating sources is a topic left for another day.*

- The insurer seemed to have no knowledge of or involvement with the Consent Form.

- To the assessment centre's credit, since it had provided sufficient warning of the Consent Form, there was time for the parties to work out an agreement. After discussion and correspondence, the parties agreed to a revised Consent Form (**Appendix C**).

- To avoid any "hiccups" at the IE, insured's counsel then forwarded a copy of the revised Consent Form to her client and advised him that it had been approved.

- The assessment centre neglected to send the revised Consent Form to the IE examiner. Accordingly, when the examiner required the original Consent Form to be signed by the insured, the insured refused, and the IE examiner refused to proceed.

Case Study #2

- Several IEs were arranged to take place at an assessment centre to determine whether the insured was entitled to income replacements after the 104 week mark.

- When the insured attended the first IE, she was asked to sign a number of forms, including a Consent Form (**Appendix D**). The Consent Form had not previously been provided to the insured, her counsel, or (it seemed) the insurer. The insured was uncomfortable signing any forms that her counsel had not reviewed, so she refused to sign. The IE examiner refused to proceed with the IE.

- In the process of re-scheduling the IE, counsel for the insured asked the insurer to obtain from the assessment centre a) a copy of the Consent Form and b) the legal basis upon which the assessment centre was relying for requiring that a Consent Form be signed.

- The Consent Form was provided. It included a number of disconcerting stipulations, including that the insured agree that:

    - since the assessment centre was also a teaching clinic, the assessment may be observed by another healthcare practitioner;

    - the written tests that may be included as part of the examination may be analyzed in collaboration with the Canadian Memorial Chiropractic College (identified only in the Consent form as "the CMCC") for research-purposes;

        - *Note: The question of whether it is even proper to require an insured to provide written tests, summaries, or questionnaires is a topic left for another day.*

  - the assessment centre could collect and use information about the insured for the provision of clinical care, administration of the health care system, quality improvement, program evaluation, statistics, research and legal and regulatory accountability purposes.

- The President of the assessment centre also provided a letter explaining that a signed Consent Form was "mandatory". He cited no legal authority for this position.

- Ultimately, the parties worked together to create a mutually agreeable revised Consent Form (attached to this paper as **Appendix E**).

- Unfortunately, as with Case Study #2, when the insured attended the re-scheduled IE, the assessment centre had failed to provide the IE examiner with the revised Consent Form. When the IE examiner insisted that the insured sign the original Consent Form, she again refused, and he again refused to proceed with the IE.

The above case studies reflect a growing number of problematic scenarios that are arising from the use of Consent Forms. These scenarios are particularly troublesome in light of the fact that there is no requirement in the *SABS*, *HCCA*, or college policies for a signed Consent Form; and that even some assessment centres recognize, when confronted, that their Consent Forms are overly intrusive. Given that insurers are often "left in the dark" by the assessment centre as to any Consent Form that will be required, there is a serious concern for those insureds who are unrepresented and being asked to sign Consent Forms.

#3: WHAT ARE THE CONSEQUENCES OF FAILING TO RESOLVE THE CONSENT FORM DISPUTE PRIOR TO THE IE?

Both insureds and insurers are suffering the consequences arising from disputes over Consent Forms.

i. What are the consequences to insureds?

Apart from the increased costs incurred by their counsel in addressing the Consent Form dispute, and the inconvenience of having to attend sometimes multiple re-scheduled IEs, the main consequence to insureds is the delay of the potential approval of a recommended treatment and/or the stoppage of ongoing specified benefits.

If the benefit at issue is a rehabilitative benefit, for instance a gym membership, the approval of funding for the gym membership will be delayed until such time as the insurer receives an IE report confirming the reasonable necessity of the proposed treatment.

If the benefit at issue is a specified benefit, for instance ongoing entitlement to IRBs, the insurer may be permitted to stop paying the benefits until the IE proceeds. In that regard, section 37(7) of the *SABS* states:

> If the insured person fails or refuses to comply with subsection 44(9) [submitting to an IE], the insurer may,
>
> (a) make a determination that the insured person is no longer entitled to the specified benefit; and

> (b) refuse to pay specified benefits relating to the period after the insured person failed or refused to comply with that subsection and before the insured person complies with that subsection.

ii. What are the consequences for insurers?

The main consequence to insurers is increased costs. Costs are increased by virtue of often having to "mediate" between the assessment centre and counsel for the insured; to re-schedule IEs that did not proceed; and/or to pay a cancellation fee to the assessment centre.

In regards to cancellation fees, section 47(1)(e) of the *SABS – Accidents On or After November 1, 1996* reads:

> A person shall repay to the insurer, fees paid by the insurer that are referred to in paragraph 8 of subsection 24 (1) if the *insured person* fails, *without a reasonable explanation*, to attend a designated assessment that has been arranged, or cancels a designated assessment without providing such notice as may be specified in the Pre-assessment Cancellation Fee Schedule established by the committee referred to in section 52, as it may be amended from time to time, that he or she will not be attending the designated assessment.

A few comments are made. First, this repayment obligation is only triggered if the *insured* cancels the IE. In the scenario most frequently seen, the IE examiner is the one refusing to go ahead. Second, if the insured is the one initiating the cancellation, the refusal to sign an improper and unnecessary Consent Form will likely be considered a "reasonable explanation" (as was the case in *Luther*). Finally, there is no mention of an insured's obligation to pay a cancellation fee in the post-September 2010 *SABS*. The

repayment section, now section 52, makes no reference to an insured's requirement to pay a cancellation fee for failing to attend an assessment.

A secondary potential consequence to insurers, particularly if they are involved in the drafting or insistence upon a signed Consent Form, may be a finding of an unfair or deceptive act or practice. Section 1(9) of the *Unfair or Deceptive Acts or Practices*[15] regulation:

> For the purposes of the definition of "unfair or deceptive act or practice" in section 438 of the *Act*, each of the following actions is prescribed as an unfair or deceptive act or practice:
>
> …
>
> Any conduct resulting in unreasonable delay in, or resistance to, the fair adjustment and settlement of claims.

In *Luther*, Arbitrator Wilson expressed concerns as to delays that are being caused by these Consent Forms. He stated[16]:

> The unfortunate aspect of this was that the process of dealing with assessors and consents took a long time. During that time, Mr. Luther was without benefits, even though the Insurer has acknowledged that, but for the assessment issue, he remained entitled to ongoing payments.
>
> …
>
> As stated before, insurers hire and pay for assessors who work under the authority of the insurer when performing section 42 examinations. It is not too much to ask the insurers vet not only the qualifications and the quality of their assessors, but their intake procedures as well, including the signing of consents.
>
> Any written consents requested should be simple, consistent, and in accordance with the purposes of the *Schedule*.

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[15] O. Reg. 7/00.
[16] *Luther*, *supra* note 5 at 14-15.

CONCLUSION

The legal position of counsel for the insured ought to be that the insured will not sign the IE Consent Form. This is an appropriate position given that, amongst other things:

1. there is no authority under the *SABS*, common law, *HCCA*, or regulatory policies to require an insured to sign a Consent Form;
2. consent is implicit in the insured's participation in the IE;
3. the insured ought not to be put to legal expenses addressing the problems with the proposed Consent Form for which she will not be reimbursed by the insurer;
4. there are still a number of IE examiners who do not make it a practice of insisting upon a signed Consent Form (such that those examiners who require a Consent Form ought not to be retained by the insurer);
5. if the insurer is required to re-schedule the IE due to a Consent Form issue, thereby delaying the timely adjustment of benefits, this may amount to an unfair deceptive act or practice.

From a practical perspective, however, there may be times when "making a mountain out of a mole hill" would not serve the insured's best interest. In circumstances where the Consent Form does not contain any particularly disconcerting terms (such as those outlined earlier in this paper) and/or where any delay to the adjustment of the insured's benefits would be particularly burdensome on or harmful to the insured, the best course may be to agree to sign the Consent Form.

The decision is one that will have to be made on a case-by-case basis, as the issue arises.

For any questions, comments, or concerns, please do not hesitate to contact Deanna S. Gilbert at Thomson, Rogers (416-868-3205 or dgilbert@thomsonrogers.com).