Accident Benefit Reporter

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IN THIS SPECIAL EDITION ISSUE

Judge Condemns Practice of Ghostwriting Expert Reports

Why it is crucial to complete and submit a Disability Certificate (OCF-3) ASAP – an important message for hospital providers

Can an insured be compensated when the PSW providing the care is a family member?

The Non-Earner Benefit Test: A Refresher

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Alan A. Farrer
PARTNER *THOMSON, ROGERS*

For over 80 years, personal injury lawyers have joined Thomson, Rogers because they share a passion for advocating for people who have been seriously injured. Every Thomson, Rogers lawyer strives to help our clients by providing them with the best possible representation.

I am happy to inform you that Thomson, Rogers has once again been recognized as one of the top Personal Injury Law Firms in Canada by Canadian Lawyer Magazine. It is a great honour to be recognized by our peers, but also to know that they have acknowledged our passion for helping people.

We would like to thank each of our clients, associates, friends, and those who have thought enough of us to make client referrals, for their continuing support. You have made this journey with us and you share in this honour. You are the primary reason we aspire to be a top personal injury law firm.

It is truly an honour to have represented so many personal injury victims over our 80 plus years of advocacy.

With our heartfelt thanks, and for the trust you have bestowed to us – thank you.

Alan A. Farrer
Managing Partner, Thomson, Rogers

JUDGE CONDEMNS PRACTICE OF GHOSTWRITING EXPERT REPORTS

Stephen M. Birman
PARTNER *THOMSON, ROGERS*

Defence medical assessments are a fact of life for Plaintiffs in personal injury litigation.

Most injured accident victims dislike the idea of attending these assessments with medical experts retained by the defendant's insurance companies. As lawyers we frequently hear from clients who call us in frustration with complaints that the medical expert had pre-determined his/her opinion, was not listening to their complaints and spent very little time with them.

Adding to the traditional issues with defence expert assessments, a practice among medical experts that an Ontario Superior Court Judge has referred to as "ghostwriting" has recently come to the attention of the Courts.

Ghostwriting occurs when the expert relies on another person to prepare all or part of their report. There are different ways this could happen, one scenario could be where a medical expert receives a large volume of medical and rehabilitation records prior to an assessment and, due to a busy clinical practice, does not have time to review and summarize all the records. This review would then be undertaken by someone other than the medical expert whose name is ultimately on the report and who might one day be required to defend the report in Court. This is problematic because the review and summary of these medical records can be used by defence experts to argue that a Plaintiff has been inconsistent in reporting their symptoms.

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In a recent decision in *Kushnir v. Macari*, Superior Court Justice Macleod Beliveau was confronted with general concerns about this so-called ghostwriting process. In that case, the Plaintiff sought as a term of a medical examination that the defence expert be the sole author of the report and that the Plaintiff's health records and information not be disclosed by the expert to any other person or entity other than defence counsel. In this decision, the Judge referred to the definition of ghostwriting as a practice, "when an expert opinion is tendered that is attributable to one author, but where the opinion contained is in fact the opinion, even in part, of people not named on the report."

The Plaintiff, in *Kushnir v. Macari*, argued that the ghostwriting of expert reports is becoming commonplace and problematic in litigation files in general, without alleging any specific wrongdoing by the assessors proposed to conduct assessments in that case. The Judge ultimately accepted these concerns as valid and ordered that the medical expert be the sole author of their report and that the Plaintiff's information not be disclosed to any other person or entity other than defence counsel.

The Judge noted that ghostwriting sometimes occurs in the legal profession, for instance in the preparation of Court materials, but distinguished those circumstances from expert reports because, "the expert is providing expert opinion evidence that can directly affect the result of the litigation and the interests of the parties."

The Judge stressed the importance of ensuring the reliability of expert reports, especially in an environment where most cases are resolved short-of-trial based on the strength of the expert's opinion.

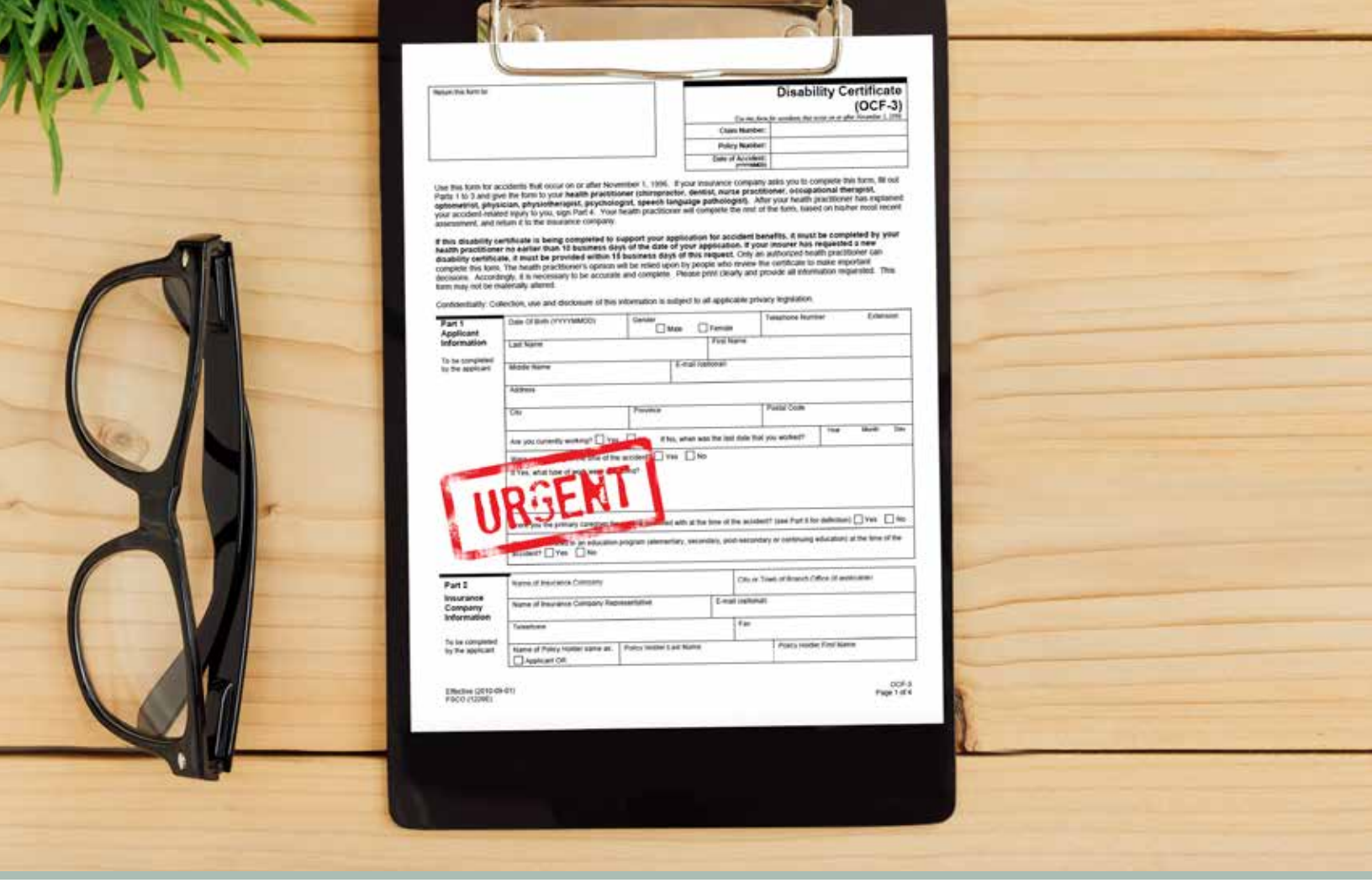
> *"The issue of who actually wrote the report is of particular concern to the litigation bar as many cases are resolved prior to trial on the basis of the expert reports received, which form the basis of counsel's assessment of the case and subsequent offers to settle. The parties pay substantial fees to experts for their reports and they have a right to expect those reports to be written by the author of the report."*

In the decision, the Judge cited an example of a case that had gone to trial in which the expert testified that someone else in fact wrote part of their report. This fact was never previously disclosed. Counsel would have been unaware of this information prior to trial as in Ontario experts are not cross-examined on their reports prior to trial. The Judge commented that this practice "wreaks havoc with the litigation process" and may promote unnecessary litigation.

The Judge issued an Order which included the term sought by the Plaintiff that the expert must be the sole author of their report and must not disclose the Plaintiff's information to any person or entity other than defence counsel. Overarching the decision was the Judge's view that defence assessments are intrusive in nature, the reports are critical to the litigation process and that transparency is required in the preparation of these reports.

I would expect and recommend going forward that Plaintiff's counsel place similar conditions on defence medical assessments as imposed in this decision.

Justice MacLeod Beliveau's decision demonstrates that while Plaintiffs are typically required to attend intrusive defence medical assessments, the insurer does not have 'carte blanche' in the manner in which the assessments are conducted and reports are prepared. Reasonable terms can and should be placed on these assessments going forward. At the bare minimum this would include a requirement that the expert actually write their own report. ■■■



Darcy R. Merkur
PARTNER *THOMSON, ROGERS*

WHY IT IS NOW CRUCIAL TO COMPLETE AND SUBMIT A DISABILITY CERTIFICATE (OCF-3) ASAP – AN IMPORTANT MESSAGE FOR HOSPITAL PROVIDERS.

Traditionally, we have explained to hospital providers that while it was best for patients to submit their Accident Benefit documents (i.e. Application and Disability Certificate) to their accident benefit insurer ASAP, there was no serious consequence associated with a delayed submission of these forms.

However, accident benefit insurers have recently been relying on a provision in the governing legislation that allows insurers to avoid ever paying certain benefits (like vital Income Replacement Benefits) for the period before they have received a completed Disability Certificate (a completed OCF-3).

Section 36(3) of the SABS (Statutory Accident Benefits Schedule) says just that–that, "An applicant who fails to submit a completed disability certificate **is not entitled to a specified benefit for any period before the completed disability certificate is submitted.**"

So, we wanted to notify you that it is more important than ever to supply patients with a completed Disability Certificate (OCF-3) ASAP… and to help make sure that patients engage an experienced and qualified personal injury lawyer ASAP to ensure their documents are all properly submitted.

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We note that income replacement benefits aren't, by law, payable for the first week after a motor vehicle accident so the rush is really to make sure the Disability Certificate is submitted by the end of that first week, wherever possible.

Of course, we have a host of compelling arguments to convince insurers that their position is wrong and that they still must pay benefits even for the period before the Disability Certificate is submitted, but because insurers can withhold paying benefits until any such dispute is addressed it is best practice to get the OCF-3 submitted ASAP.

KEY TIPS FOR COMPLETING A DISABILITY CERTIFICATE (OCF-3):

- Do not describe the accident in any details (all that is needed is: 'pedestrian hit by a car' or 'passenger in vehicle involved in collision' or 'driving and made contact with another vehicle'- (all too often negative details are inserted that haunt claims and this is just a formality to ensure the injuries were caused in a car accident as opposed to a fall, etc.)
- If there are whiplash symptoms, list those last and focus/highlight any fractures and/or any concussion (to ensure the claim is NOT thrown into the Minor Injury Guideline)
- Ensure that the questions about 'ability to work' and about 'complete inability to carry on a normal life' are completed properly to confirm the patient is not currently able to work or carry on a normal life (this question qualifies a claimant for income replacement benefits or non-earner benefits)

Should you have any questions, please feel free to call or email personal injury lawyer Darcy Merkur. ■■■

Stacey L. Stevens
PARTNER *THOMSON, ROGERS*

CAN AN INSURED BE COMPENSATED WHEN THE PSW PROVIDING THE CARE IS A FAMILY MEMBER?

On January 27, 2017, the License Appeal Tribunal released *M.P. v Certas Home and Auto 2017 CanLII 9810 (ON LAT)*, denying payment of an attendant care benefit to an insured whose service provider was his wife and a certified PSW.

This is an important decision as it addresses the Tribunal's interpretation of the definition of incurred found in section 3(7)(e) of the SABS, and how it applies in cases where the professional PSW providing the care is also family member.

Mr. P was injured in a car accident in July 2013. An Assessment of Attendant Care Form 1 determined he required 915 minutes of personal care assistance per week. At the time of the collision, Mrs. P was a certified PSW and working outside of the home providing live-in assistance to seniors 3 days a week. She provided PSW care to her husband during the remaining 4 days a week.

In January of 2015, Mrs. P stopped providing PSW services outside the home and increased the number of hours and days she provided care to her husband. Certas denied payment of the attendant care benefit, and the Tribunal upheld the denial.

As set out in the Statutory Accident Benefits Schedule (SABS), an insured person is entitled to reasonable and necessary expenses incurred as a result of an accident for services provided by an aide or attendant. In order to be entitled to payment of the expense, section 3(7)(e) of the SABS states that an expense is not incurred unless,

> *The person who provided the goods or services did so in the course of the employment, occupation or profession in which he or she would ordinarily have been engaged but for the accident or sustained an economic loss as a result of providing the goods or services to the insured person.*

The reasoning behind this section was previously interpreted by Justice Ray of the Ontario Superior Court of Justice in *Henry v. Gore Mutual* 2012 ONSC 3687 as follows:

> This latest revision was apparently to prevent a member of an insured's family who was not ordinarily an income earner or working outside the home, from profiting from an attendant care benefit, when they would likely be at home anyway - and would have looked after the injured insured without compensation.

With this in hand, Adjudicator Sewrattan found Mrs. P to be *"at the intersection of these 2 classes", a family member who is professionally qualified to provide the requisite attendant care services.*

He went on to find that Mrs. P's provision of care services to her husband was specifically the type of work the Legislation attempted to disqualify and therefore it did not fit within the category of a professional provider as required.

It may very well be that the particular factual evidence put forward in this matter is enough to argue that the decision is case specific. After a review of the evidence, the Adjudicator was left with many unanswered questions such as did Mrs. P work more than 3 days per week as a PSW before the collision, did these hours decrease as a result of having to provide care to her husband or for other reasons not causally related to the accident such as a lack of available work outside the home or her pre-existing sciatica; was the level of care being provided to Mr. P similar to the type of care she would have been providing to her husband in her free time without the collision and without remuneration.

This case may also be a sign of things to come. Insurers are strictly interpreting the SABS and the insured's right to receive an attendant care benefit. It is possible, with this decision in their back pocket, we will see more and more cases where insurers will only pay an attendant care benefit if it is being provided by an arms-length professional.

Either way, this case demonstrates the need for a strong evidentiary foundation, and illustrates the key role rehabilitation team members have in ensuring their clinical notes and records accurately and completely document their clients needs. ■■■

Robert M. Ben
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THE NON-EARNER BENEFIT TEST: A REFRESHER

Lawyers routinely rely on the expertise of healthcare and rehabilitation professionals to establish their injured clients' eligibility for accident benefits. Car accident injury victims who cannot work may be entitled to an income replacement benefit (IRB). Those who do not qualify for an IRB (full-time students, recent graduates, stay-at-home parents, unemployed and retired persons) may qualify for payment of a "non-earner" benefit (NEB).

For accidents that happened before June 1, 2016, the benefit was payable after the applicable six month waiting period in the amount of $185.00 per week for the first two years and then $320.00 per week for life, provided the injured person established he or she "suffers a complete inability to carry on a normal life" as a result of an accident-related impairment. For accidents occurring on or after June 1, 2016 (subject to certain exceptions) the NEB is significantly curtailed, and only payable to eligible claimants at $185.00 per week for a maximum of two years after a four week waiting period.

The NEB has always been a contentious benefit from the perspective of insurance companies. Insurers often deny payment of the NEB on the basis of an expert medical or other opinion stating that the claimant does not meet the test of "complete inability to carry on a normal life." A literal reading of the test would suggest that eligibility would be reserved for only the most extreme injury victims. However, that is not the case.

Over the years, numerous arbitration and court decisions have interpreted the NEB test in a more nuanced rather than literal fashion. Unfortunately, medical and health professional experts are often not properly instructed by the lawyers who have sought out their expertise on the legal interpretation of the NEB test. Injury victims would be treated more fairly by their insurers and get better access to the benefits they are entitled to if more care was taken by lawyers to assist experts in understanding the appropriate analytical approach that arbitrators and courts demand in order to satisfy the NEB test.

The starting point is the accident benefits legislation. Section 12(1) of the *Statutory Accident Benefits Schedule* provides, in relevant part, as follows:

> 12. (1) The insurer shall pay an insured person who sustains an impairment as a result of an accident a non-earner benefit if the insured person meets any of the following conditions:
>
> 1. The insured person suffers a complete inability to carry on a normal life as a result of and within 104 weeks after the accident and does not qualify for an income replacement benefit.
>
> 2. The insured person suffers a complete inability to carry on a normal life as a result of and within 104 weeks after the accident and,
>
> i. was enrolled on a full-time basis in elementary, secondary or post-secondary education at the time of the accident.

Section 3(7)(a) of the *Schedule* provides that "a person suffers a complete inability to carry on a normal life as a result of an accident if, as a result of the accident, the person sustains an impairment that continuously prevents the person from engaging in substantially all of the activities in which the person ordinarily engaged before the accident."

The leading authority on the NEB test is the Court of Appeal for Ontario's decision in *Heath v. Economical Mutual Insurance Company* (2009). 5 O.R. (3d) 785 (C.A.) where the court detailed the proper analytical approach to be undertaken:

> • Generally speaking, the starting point for the analysis of whether a claimant suffers from a complete inability to carry on a normal life will be to compare the claimant's activities and life circumstances before the accident to his or her activities and life circumstances after the accident. This follows from the language of the section as well as a review of the predecessor provisions.
> That said, there may be some circumstances in which a comparison, or at least a detailed comparison, of the claimant's pre-accident and post-accident activities and circumstances is unnecessary, having regard to the nature of the claimant's post-accident condition.

• Consideration of a claimant's activities and life circumstances prior to the accident requires more than taking a snap-shot of a claimant's life in the time frame immediately preceding the accident. It involves an assessment of the appellant's activities and circumstances over a reasonable period prior to the accident, the duration of which will depend on the facts of the case.

• In order to determine whether the claimant's ability to continue engaging in "substantially all" of his or her pre-accident activities has been affected to the required degree, all of the pre-accident activities in which the claimant ordinarily engaged should be considered. However, in deciding whether the necessary threshold has been satisfied, greater weight may be assigned to those activities, which the claimant identifies as being important to his/her pre-accident life.

• It is not sufficient for a claimant to demonstrate that there were changes in his or her post-accident life. Rather, it is incumbent on a claimant to establish that those changes amounted to him or her being continuously prevented from engaging in substantially all of his pre-accident activities. The phrase "continuously prevents" means that a claimant must prove "disability or incapacity of the requisite nature, extent or degree which is and remains uninterrupted."

• The phrase "engaging in" should be interpreted from a qualitative perspective and as meaning more than isolated post-accident attempts to perform activities that a claimant was able to perform before the accident. The activity must be viewed as a whole, and a claimant who merely goes through the motions cannot be said to be "engaging in" an activity. The manner in which an activity is performed and the quality of performance post-accident must also be considered. If the degree to which a claimant can perform an activity is sufficiently restricted, it cannot be said that he or she is truly "engaging in" the activity.

• In cases where pain is a primary factor that allegedly prevents the insured from engaging in his or her former activities, the question is not whether the insured can physically do these activities, but whether the degree of pain experienced, either at the time, or subsequent to the activity, is such that the individual is practically prevented from engaging in those activities.

Under the *Heath* analysis, the question of whether the injuries sustained by the plaintiff's accident prevented her from engaging in substantially all of the activities in which she ordinarily engaged before the accident is to be viewed from a "qualitative perspective" requiring the relevant activities to be viewed as a whole, with the manner in which each activity is performed and quality of performance post-accident to be considered. Activities, which were more important to the claimant, will be weighed more heavily under this analysis. In the case of *Galdamez v. Allstate Insurance Company of Canada*, 2012 ONCA 508, the Court of Appeal held that "substantially all" does not mean "all", although arbitration decisions from the Financial Services Commission of Ontario such as *Todd v. State Farm* (FSCO A00–001314, 2003) have held that "substantially" means more than a "goodly number" or even a majority.

The mere fact that an injured person is working full-time does not automatically disentitle him or her to non-earner benefits. In *Galdamez* the court held that a person who suffers a severe diminution in their overall quality of life could still meet the test of entitlement to an NEB even if they are working.

The court gave the following example: "…in jobs where mobility is not a requirement (e.g., department store greeter, telemarketer, etc.), and the job was not of great importance in the claimant's pre-accident life, it may be possible for a claimant who returns to his or her pre-accident employment following an accident to satisfy the test for non-earner benefits." However, the court did caution that such situations will be "rare" and "unlikely", the "possibility" still exists.

All of this is to say that the seemingly simple NEB test is not so simple. It is crucial that medical and health professional experts who have been asked to render an opinion on NEB eligibility understand the analytical approach demanded by courts and arbitrators. Otherwise, their expert opinions are going to be given any weight. ■■■

UPCOMING EVENTS 2017

EVENTS
2017

May 4 & 5 Hamilton ABI Conference - Hamilton Convention Centre, Hamilton.

May 10 ABI Community Agency Fair – Mattamy Athletic Centre, Toronto.

May 11 BIAPH's 9th Annual "Une Affaire de Chocolat" Social Mix & Mingle – Compass Restaurant, Oakville.

June 1 Practical Strategies Webinar: – A Year in Review: Understanding the impact of the SABS changes.

June 14 BIST/OBIA Mix and Mingle – Steam Whistle Brewery, Toronto.

June 23 Birdies for Brain Injury Golf Tournament – Lionhead Golf and Country Club, Brampton.

September 28 Back to School Conference: ABI Across the Ages – The Carlu, Toronto.

October 1 BIST 5K Run, Walk and Roll in Support of Acquired Brain Injury – Wilket Creek Park, North York.

Nov 1-3 Acquired Brain Injury Provincial Conference – Sheraton on the Falls Hotel, Niagara Falls.

FOR MORE INFORMATION ON UPCOMING EVENTS, PLEASE VISIT:
https://www.thomsonrogers.com/news/upcoming-events/

If you have any questions regarding the articles in this issue of the Accident Benefit Reporter, please contact the following authors:

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2016 was a big milestone for Thomson, Rogers, as we celebrated our 80th anniversary.

We wanted to mark this time in our history with an event that would be reflective of who we've been over the years and who we strive to be in the future. We decided to donate $80,000 to a number of different charities to help them with their objectives and to raise awareness for their causes at the same time.

We were pleased with this campaign and the feedback we've received from our associates, partners and the public. We'd like to thank everyone who helped make this campaign a great success, and we look forward to many more years of charity and support.

Accident Benefit Reporter is a publication of Thomson, Rogers

Want more information about topics such as the new Statutory Accident Benefits Changes, catastrophic definitions and proceedings through the License Appeal Tribunal? At Thomson, Rogers we pride ourselves in keeping you informed. For a TR lawyer to provide an informative presentation to your company or to a group of any size contact **Joseph Pileggi - 416-868-3190**, jpileggi@thomsonrogers.com.

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