Collateral Disclosure Strategies in Ontario Automobile Litigation:

SABS*, *PIPEDA* and the *RHPA

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Ontario's no-fault automobile insurance regime relies heavily on medical or functional assessments by independent health care professionals. Without doctors and other health care professionals, much of automobile accident litigation in Ontario could not function. This article introduces a practice development in this field that, if adopted more widely, could bring much of the process to a halt.

The IME in Motor Vehicle Accident Litigation

Since the early 1990's, statutory automobile insurance accident benefits have in part replaced civil actions for tort claims arising from motor vehicle accidents. "No-fault" means the party's entitlement to insurance funding for treatment, income replacement or attendant care does not depend on the liability of another driver or observance of the rules of the road. Rather, the right to funding depends on the extent of an injury and resulting "impairment." Only health care professionals are qualified to assess the existence and extent of an impairment.

When motor vehicle accident victims apply for benefits under the *Statutory Accident Benefits Schedule* ("SABS"),[1] they will usually enlist the help of their own family doctor to state they require treatments or are unable to work, and fill out a prescribed document known as "OCF" forms.[2] The insurer can either accept the impairment or dispute it. When such disputes occur, the insurer is required to decline the application and may require the claimant to undergo one or more

[1] The no-fault automobile insurance regulation under the *Insurance Act*, R.S.O. 1990, c. I.8, s. 268.
[2] https://www.fsco.gov.on.ca/en/auto/forms/pages/ocf_forms.aspx

assessments by an independent health care practitioner. The claimant then has the choice of undergoing the examination or forego the benefit. Such independent assessments, commonly known as "IME's" (independent medical examinations[3]), exist within a formal dispute resolution mechanism for early determination of most claims for accident benefits following a motor vehicle accident. The insurers' authority to require an examination is s. 44 of SABS. Other provisions calling for insurer examinations refer back to the procedure under s. 44, as a matter of legislative consistency.

Under the s. 44 procedure, an insurer can refer a claimant for examination by a regulated health professional (eg., physician, occupational therapist, etc., as appropriate) an obtain a report for the sole purpose of assisting the insurer to determine whether a claimant is entitled to benefits. Insurers can refer examinees directly to the professionals. It is now more common for insurers to delegate the referral to a private company to co-ordinate appointments with the health care professionals. The companies, licensed under regulations under s. 288.2 of the *Insurance Act*, perform an intermediary role of custodian of records, coordinator of multi-disciplinary referrals, and quality assurance (QA) in the preparation of assessment reports. The QA function of these companies now standardizes practices such as records assembly, editing and proofreading formerly performed by medical secretaries in doctors' offices. Assessors performing the examinations contract with the companies to receive appointment referrals. Once an insurer refers a claimant for examination, the assessment companies will set up an appointment with a health care professional. Whether the insurer refers a claimant directly to an assessor or retains a company to perform this task, the assessor's only role is to examine the claimant and provide an opinion to the insurer. There is no legal relationship between the assessor and the examinee, apart from professional ethical requirements specific to the health care discipline regarding consent and competence in the performance of the examination.

The s. 44 examination is part of a formal dispute resolution process because it is employed in cases where the insurer contests the claimant's entitlement to benefits or to enhanced benefits by applying for "catastrophic" impairment status. For example, no reasonable insurer would deny

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[3] In this article, "medical" will refer both to traditional medicine as well as allied health care professions such as occupational therapy, physiotherapy, vocational therapy, psychology, etc.

such status to an obvious candidate such as a spinal-cord compromised person who has clearly lost a major bodily function. In such instances, insurers may require assessments on consent in order to determine the extent of treatments and services an accident victim requires. If a dispute arises, it usually becomes subject to informal negotiation. It is in less obvious cases, where there exists some doubt about the level of impairment, that insurers invoke the formal dispute resolution process. As a consequence of decline in the number of serious automobile accidents, more cases landing on lawyers' desks are likely to be disputed by insurers over the extent of benefits to which clients are entitled. Thus, the s. 44 examination process has become a battleground for accident-benefit litigation. The insurer's right to require an examination leaves in most cases leaves little or no room for a claimant to object. Ordinarily, as in the case of any litigation involving scientific expert witnesses, the statutory regime contemplates cross-examination during the arbitral hearing as the way to expose any deficiencies in the opinion arising from an IME. However, the absence of a legal platform for litigating the pre-hearing process of s. 44 examinations has not deterred lawyers from extrajudicial methods. This paper aims to introduce the litigation Bar of Ontario to extrajudicial tactics, and how they have suppressed participation by medical experts.

Litigating Consent

There is no provision in s. 44 governing a claimant's consent to being examined by a health care practitioner chosen by the insurer. If the claimant refuses to be examined, he or she does so at peril of losing access to benefits. There is no free and informed consent in the sense employed in therapeutic settings. The procedure is a form of compelled disclosure similar to the medical examinations that courts can order in civil proceedings. Legally, consent to examination plays no role in s. 44 under the SABS.

In the health care industry, informed consent is a cornerstone of ethical practice. In the therapeutic setting, however, consent is rarely an issue because patients seek the help of doctors and other professionals to relieve their ailments. Medical negligence or malpractice claims do result from informed consent issues, mostly in the case of elective medical interventions. In comparison to the large number of medical interactions in a country like Canada, such law suits

are relatively rare.[4] Nevertheless, health care professionals are mandated by their professional colleges to ensure patients and clients consent to examinations and treatments because the lack of consent to any form of touching – a necessary element of many diagnostic procedures – can be considered assault or battery.

Consent is also a factor in IME practice, not because it is part of the s. 44 process, but rather because the health care professions mandate a heightened sensitivity to consent issues when the procedure is not therapeutic. An obstetrician might have a cursory and urgent discussion with a mother when a difficulty vaginal birth requires an emergency Caesarean section. In contrast, there would be consultations, forms to fill and cooling-off periods before a cosmetic surgeon embarks on elective liposuction. In this context, the lack of therapeutic purpose for an independent medico-legal examination means doctors and other health care workers will feel obliged to obtain fully informed consent, even though legally the person being examined has no choice in the matter if he or she wishes to continue applying for the accident benefits.

The health care professional performing an assessment needs to interact with the insured claimant, physically examine the person where warranted, and review confidential medical records. Depending on the discipline, informed consent can vary from best practice to ethical requirement. Medical doctors in Ontario must navigate a contextual guideline that ranges from recommending or requiring consent, depending on the circumstances.[5] Occupational therapists, who are frequently retain as part of a multi-disciplinary referral for catastrophic impairment rating, are required to obtain informed consent in all IME's.[6] These consents are required to protect the practitioners from potential claims of assault or malpractice. In the context of a s. 44 assessment, however, the claimant's consent to the touching, in the case or a physical examination, or intrusion on privacy, in the case of an interview or review of records, is compelled by law. The only legitimate way to avoid the medical interaction is to withdraw the claim for benefits.

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[4] Q.v. *Reibl v. Hughes*, [1980] 2 S.C.R. 880, as an illustration of the difficulty of litigating consent to treatment in the therapeutic medical field.

[5] "Third Party Reports," College of Physicians and Surgeons of Ontario: https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Third-Party-Reports

[6] "Standards for Consent," College of Occupational Therapists of Ontario: https://www.coto.org/docs/default-source/default-document-library/revised-standards-for-consent-july-18-2016.pdf?sfvrsn=2

In court-ordered medical examinations of claimants or plaintiffs, such as those allowed to defendants as of right under s. 105 of the Ontario *Courts of Justice Act*, R.S.O. 1990, c. C.43, and rule 33 of the Ontario rules of civil procedure, parties often dispute procedural conditions such as videotaping and the supply of clinical information.[7] Such disputes stem from the discretionary nature of the order and the statutory wording that the court "may" order such examinations, even though in practice the courts tend to order the examinations as of right.

In contrast, s. 44 of the SABS confers no discretion on any tribunal to dictate terms, at least with respect to the first examination. Nevertheless, it has now become commonplace for counsel representing statutory accident benefits claimants to attempt to negotiate terms with an automobile insurer in the scheduling of s. 44 examinations. Consent has been used as leverage to obtain perceived advantages in the process, such as advance disclosure of draft reports to provide fodder for impeachment of experts at the hearing. A high-profile defamation case between a medical assessor and an Ontario plaintiff personal injury lawyer[8] has shined a spotlight on a perception in the personal injury bar that assessors hired by insurers are biased or have allowed assessment companies to interfere with their objectivity. In an effort to obtain disclosure of the contracts for hiring assessors, including those involving assessment companies, counsel for accident benefits claimants have even gone as far as refusing to participate in IME's. Arguing that insurers' use of assessment companies is "unlawful," one counsel advised his client to withhold consent even though it meant the client could be barred from seeking entitlement to benefits. Rejecting this argument, the Ontario Licence Appeals Tribunal (LAT) found nothing unlawful with the involvement of assessment companies:

> Section 44 of the SABS does not prohibit insurers from retaining third party service providers to conduct IEs. A third-party service provider could directly employ persons, or retain independent contractors, to do so. The legal requirement is that whoever actually performs the assessment must be a regulated health professional.[9]

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[7] Eg.. *Safi v. Steele*, 2009 CanLII 15887 (ON SCJ).

[8] *Platnick v. Bent*, 2018 ONCA 687 (CanLII)

[9] *18-006654 v Royal Sun Alliance Insurance (RSA)*, 2019 CanLII 34605 (ON LAT), at para. 17. The same arbitrator also ruled that the assessment company was "an agent of the insurer" (para. 19). This ruling was dubious because assessment companies do not perform functions on the insurers' behalf. Rather, they provide medico-legal administrative services.

At least one Ontario law firm has attempted to provoke similar disputes by refusing to permit their clients to be examined under s. 44 unless the examiner used the law firm's approved consent form. The form makes consent conditional on the exclusion of assessment companies from the process of performing QA services in the preparation of medico-legal reports. Such attempts to withhold consent or to impose terms on consent outside the wording of the s. 44 regulation are unlikely to succeed, since it is a statutory process in which the dispute resolution process does not grant authority to the Licence Appeals Tribunal to interfere with the insurer's right to an IME or impose terms. The only consent required is a form signed by the examinee acknowledging the medico-legal purpose of the examination and the informed agreement to be interviewed and examined.

The compellable nature of the s. 44 insurer examination thus renders attempts to withhold consent to secure more advantageous terms a game of cat-and-mouse that cannot end well for the insured personal injury client. The regulation presumes that a regulated health professional will abide by the standards of the given profession, and non-compliance can be enforced through professional discipline or by cross-examination in the hearing of the dispute. From the assessor's perspective, an insured's refusal to consent to the assessor's examination in the manner acceptable to the assessor will only result in a cancellation of the appointment, with cancellation fees charged to the non-compliant insured.

Litigating PIPEDA

In about 2016, assessors began to receive cryptic letters from the clients of lawyers retained to advance injury claims. The letters invariably followed a template containing the client's name, the lawyer's office address, and the client's signature. Written in "legalese," the letters demanded that s. 44 assessors account directly to the claimant for various documents and procedures in the IME process.[10] The letters stated that the recipients were not to disclose the requests to insurers or other parties, thus leaving assessors worried that reprisals would follow if they alerted insurers or their agents. They also demanded responses within 30 days, failing which the assessor was liable to face a complaint to the Office of the Privacy Commissioner (OPC) under the Canadian

[10] Eg., as described in *P. M. v A. F.*, 2018 CanLII 39400 (ON HPARB)

federal *Personal Information Protection and Electronic Documents Act* (PIPEDA).[11] The letters exploited ostensible procedural conflicts among health care standards, privacy litigation and the SABS.

In order to gain perspective on the incongruity of PIPEDA in the s. 44 context, it may be helpful to recall the legislative history leading to the 2000 enactment of PIPEDA. The statute was sponsored driven by Industry Canada as a means of promoting public confidence in the new digital economy. The Office of the Privacy Commissioner was placed in charge of administering PIPEDA because of its role under existing legislation regulating the collection of information by federal government agencies. Poorly drafted and laden with vague, aspirational "principles," PIPEDA was more political than legal:

> When the Personal Information Protection and Electronic Documents Act, or PIPEDA, received Royal Assent in 2000, the need for private sector privacy legislation at that time was clear – Canadians were demanding adequate privacy protection in a new digital economy. In debates leading up to the adoption of the law, then-Industry Minister John Manley told the House of Commons, "All of us, consumer, business and government alike, need to feel confident about how our personal information is gathered, stored and used. The protection of our personal privacy is a basic right which Canadians cherish."[12]

The use of the legislation to gain advantages in injury litigation or insurance claims therefore falls outside the purpose of promoting consumer confidence when they shop online, or when applying for financing on a new car. Therefore, the first question that one must ask as a recipient of a "PIPEDA request" in the course of such litigation or claims is whether the custodian of the personal information is engaged in a "commercial activity" when it obtained the information. The scope of PIPEDA has been interpreted by the courts to include parties collecting information regarding a private disability insurance claim.[13]

The commercial nature of the SABS insurer's activity does not end the inquiry. Under s. 9(3)(d) of PIPEDA, an individual's right to access to personal data collected by the insurer may

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[11] S.C. 2000, c. 5

[12] Forward to *Leading by Example: Key developments in the first seven years of the Personal Information Protection and Electronic Documents Act*, Office of the Privacy Commissioner, May 2008, : https://www.priv.gc.ca/media/2007/lbe_080523_e.pdf

[13] *Wyndowe v. Rousseau*, 2008 FCA 39 (CanLII)

be denied if the collection takes place in the course of a formal dispute resolution process. The most obvious application of the exemption is information collected for use in court litigation. For example, surveillance collected during the course of a defence of a tort action has been held not to be commercial in nature, because business before the courts is not commercial.[14] PIPEDA thus cannot be used to circumvent the court rules for obtaining disclosures. The application of the s. 9(3)(d) exemption is less obvious in the case of a s. 44 examination under SABS. Is it part of a formal dispute resolution process or simply part of adjusting an insurance claim?

An IME performed as of right under a contract of disability insurance, before an insurer determines availability and scope of insurance benefits, was held not to engage the exemption under s. 9(3)(d) of PIPEDA for information gathered in the course of a formal dispute resolution process:

> … nothing in the documents provided to the complainant (such as the claim form, the short- and long-term disability benefits descriptions, or the notification that his benefits were being terminated) suggested that the role of the independent medical examiner arises in the context of resolving a formal dispute. In fact, the benefits documents indicated that the insured must report for a medical examination as often as may reasonably be required by a licensed doctor of the insurer's choice. Even the letter notifying the complainant that his benefits were being terminated made it clear that the examiner's role was to assist the insurance company in determining its position with respect to the complainant's continuing claim for benefits. It also informed the complainant that he could initiate a dispute resolution process if he was not happy with the decision. *Such a process, noted the Assistant Commissioner, would have been engaged after the independent medical examination, not before*.[15] [italics added]

Unlike the contractual procedures for IME's in disability insurance policies, the most frequently invoked provisions of Ontario's SABS regulation require the insurer at least provisionally to decline coverage before being able to carry out a s. 44 examination. The Ontario statutory accident benefits regulation provides mandatory no-fault insurance benefits to automobile accident victims for losses such as medical expenses, attendant care, and income replacement. Insurers are not required to order medical examinations. In situations where the insured accident victims are obviously catastrophically injured, such as those suffering spinal cord

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[14] *State Farm Mutual Automobile Insurance Company v. Privacy Commissioner of Canada*, 2010 FC 736 (CanLII). Also see PIPEDA Case Summary #2016-011, Office of the Privacy Commissioner of Canada

[15] PIPEDA Case Summary #2005-306, Office of the Privacy Commissioner of Canada

trauma or diffuse axonal brain injury, insurers will usually pay benefits immediately and accept that the insured is deemed to have a "catastrophic" impairment that makes available a larger scope of benefits. In less obvious cases, insurers are required to decline the coverage if they do not want to accept coverage immediately. Under SABS, s. 45 provides a process for resolving disputes over an insured victim's status as a "catastrophic" claimant:

> (3) Within 10 business days after receiving an application under subsection (1) prepared and signed by the person who conducted the assessment or examination under subsection (2), the insurer shall give the insured person,
>
> (a) a notice stating that the insurer has determined that the impairment is a catastrophic impairment; or
>
> (b) a notice *stating that the insurer has determined that the impairment is not a catastrophic impairment* and specifying the medical and any other reasons for the insurer's decision and, if the insurer requires an examination under section 44 relating to whether the impairment is a catastrophic impairment, so advising the insured person. O. Reg. 34/10, s. 45 (3). [italics added]

The regulation is worded in a similar manner, in respect of other benefits. (The only provisions which do not require the insurer to decline coverage are those allowing the insurer to monitor entitlement periodically.) The insurer is required to decide whether to accept an application within a tight timeframe. If the insurer disputes the insured's entitlement, the insurer is required to deny the application. It is therefore usually upon such an initial denial does the s. 44 examination procedure is invoked. To follow the logic of the refusal to exempt contractual IME's in the disability context, the insurer must dispute the claim before, not after, the s. 44 examination.

The s. 44 examination is also a means of resolving the dispute because it requires the insurer seeking the medical examination to do so in a transparent manner and provide the health practitioner's report. Once an insurer opts to invoke the right to an examination, the following procedure applies:

> **Examination required by insurer**
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> 44. (1) For the purposes of assisting an insurer to determine if an insured person is or continues to be entitled to a benefit under this Regulation for which an application is made, but not more often than is reasonably necessary, an insurer

> may require an insured person to be examined under this section by one or more persons chosen by the insurer who are *regulated health professionals or who have expertise in vocational rehabilitation*. O. Reg. 34/10, s. 44 (1). [italics added]

Section 45(2) provides that the examination to assist an insurer make a determination of catastrophic impairment must be a physician, but the physician may be assisted by other regulated health care professionals. In practice, this means insurers delegate the appointment of experts to private assessment agencies to coordinate examinations and reports among physicians and other professionals, such as occupational therapists, speech therapists and vocational evaluators. The regulated health professionals, including the physicians, have a purely advisory role and do not make the determination for the insurer. Although insurers usually follow IME experts' opinion, the decision remains that of the insurers.

An examination under s. 44 of SABS, where conducted *after* the insurer has been required to decline benefits, albeit provisionally in most instances, is therefore a formal dispute resolution process because the IME is intended to help the insurer determine whether the denial of coverage should be maintained or set aside. In fact, the insurer is entitled to maintain the denial if the insured does not submit to the examination. Thus, in most instances where SABS benefits are contentious, the threat of a complaint to the OPC against the assessor, the assessment company or the insurer under privacy protections under PIPEDA represents an empty threat because of the exemption under PIPEDA for information gathered under a formal dispute resolution process. As an attempt to circumvent the jurisdiction of the LAT to deal with disclosure issues, the letters addressed to assessors simply prey on health professionals' deference to lawyers in legal matters and preference to cooperate rather than risk a frivolous complaint to their professional bodies.

Assessors receiving demands from lawyers for compliance with PIPEDA are generally unaware that their professional regulators lack jurisdiction to deal with complaints arising from breaches of the federal privacy statute. The entity that has jurisdiction over PIPEDA is the OPC. It is only after a report by the OPC finding a breach of the Act that an affected party can seek enforcement of the Act before the Federal Court of Canada. Therefore, a threat to complain to a regulatory body such as a provincial professional college is misleading because such entities do not have the jurisdiction or the expertise to determine whether there has been a breach of the

privacy regime. Professional codes refer generally to members' obligations to abide by the law, but determination of legal questions and enforcement of the law are a matter of jurisdiction.

Indeed, the gatekeeper role of the OPC under PIPEDA means there is no direct right to sue for damages arising from a privacy breach. Under s. 14, a plaintiff can only sue after a Privacy Commissioner report rules in the individual's favour that an organization has breach his or her rights under PIPEDA. Thereafter, the report is not binding on the court, and the court is at liberty to disagree that there was ever a breach. Moreover, damages are not easy to obtain. In *Randall v. Nubodys Fitness Centres*,[16] the court held that damages should only be awarded "in the most egregious situations," such as videotaping in private quarters and phone tapping. A *bona fide* mistake in the handling of personal information therefore cannot give rise to automatic liability for damages. Similarly, in *A.T. v. Globe24h*,[17] the court awarded $1,500 in damages against a company that published the complainant's private information online. Having regard to the case law, a custodian of records' delay or flawed refusal to provide access to data generated in an insurance claim or law suit would be difficult to place in a category of complaint deserving an award of damages.

Having regard to the regulatory context of PIPEDA, the OPC has been reluctant to entertain privacy breach investigations against assessors, assessment companies and other participants. The rationale has been that the OPC considers such complaints to be a waste of public resources, when the Ontario government has established bodies and procedures to deal with records disclosure issues.[18] A PIPEDA request containing a threat of damages would likely be misleading and unprofessional. Thus, where a lawyer or law firm sends out "PIPEDA requests" as a matter of course, threatening dubious legal remedies, the practice is akin to bulk demand letters that breach lawyers' obligations not to abuse their professional status.[19]

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[16] 2010 FC 681
[17] 2017 FC 114
[18] OPC file no. PIPEDA-035350, Decision June 6, 2008 (unreported)
[19] *Law Society of Upper Canada v. Deanna Lynn Natale*, 2013 ONLSHP 22 (CanLII). See also Salyzyn, "Zealous Advocacy or Exploitive Shakedown?" *Windsor Review of Legal and Social Issues*, 36:1 (2015)

Litigating Assessors' Professional Ethics

The attempts to intimidate IME assessors through the litigation of consent and compliance with privacy legislation are often precursors to complaints to professional bodies. Such complaints are governed by the Health Professions Procedural Code, a schedule to the *Regulated Health Professions Act*, 1991, S.O. 1991, c. 18 (RHPA). The detailed analysis of the practice and procedure of professional colleges in the health professions is beyond the scope of this article. To summarize the course of a complaint, colleges governing professionals in the health professions are all required to convene an Inquiries, Complaints and Reports Committee (ICRC) to respond to every complaint from a member of the public. The ICRC is the front-line investigative body, charged with the task of gathering information and corresponding with the complainant and the accused. Because of the inquisitive (as opposed to adversarial) nature of the committee mandate, it filters the information available to both sides and ultimately makes a provisional decision either to halt the investigation, to mediate a resolution or penalty short of discipline, or to recommend referral to a discipline committee. Because of the latter two outcomes can result in the regulatory measure being published against the member's record, the only real option for the assessor is to steer the committee to the first outcome. In fact, an apparently benign result such as Specified Continuing Education and Remediation Program (SCERP) can arise from a complaint that would more appropriately have been as points for cross-examination at a LAT hearing. Instead, brought as a regulatory complaint, a SCERP can have a lasting impact on a member's career because of the recording and publication of a technical finding of misconduct.[20] Most professionals place a high value on an unblemished regulatory record. In such instances, it is imperative that the IME assessor retain counsel at first instance to respond vigorously to the complaint, so that the only outcome is the discontinuance of the investigation. In almost every instance where a complaint has been brought to a professional college in an attempt to litigate s. 44 outside the *Insurance Act* process, the ICRC's decision to halt a complaint investigation was upheld on appeal.[21]

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[20] *K.L. v V.T.*, 2017 CanLII 80945 (ON HPARB)

[21] *S.I. v M.R.*, 2018 CanLII 14311 (ON HPARB); *J.T. v T.L.L.*, 2017 CanLII 62880 (ON HPARB); *J.T. v B.M.*, 2017 CanLII 62879 (ON HPARB); *J.T. v J.J.*, 2017 CanLII 62878 (ON HPARB); *J.T. v A.R.M.U.*, 2017 CanLII 31113 (ON HPARB); *B.M. v J.G.*, 2017 CanLII 529 (ON HPARB); *BM v KL*, 2012 CanLII 12411 (ON HPARB)

EFFECTIVE RESPONSES TO INTERFERENCE IN S. 44 IME'S

As legislative changes to the Ontario automobile accident and insurance regime tighten the availability of remedies and compensation, and as serious motor vehicle accidents become less frequent, inventive lawyers have pursued more aggressively the IME as a battleground for litigation. Tactics such as litigating consent, threatened privacy complaints, and complaints to regulatory colleges have resulted in medical members of the medico-legal community to turn down work from insurers. In the result, insurance companies have encountered difficulties in some cases in finding health care professionals willing to perform IME's depending on the lawyer or law firm whose name appears on the file. This, of course, can lead to a breakdown in access to justice if insurers are unable to make timely decisions. In the face of such tactics, the lawyer acting for the insurer, assessor or assessment company must return to the first principle of good lawyering and advocacy: a firm understanding of the law in which the remedies are being sought. If a large enough number of Ontario lawyers engaged in the disruption of s. 44 IME's as a matter of course, the pool of available participants from the medical community will undoubtedly decrease to critical levels.

At the root of the s. 44 IME process under SABS is a simple and efficient method of resolving first-party insurance disputes arising from motor vehicle injuries. An insurer who does not accept an application for statutory accident benefits can (and should, in most instances) be assisted by a health care professional. Any attempts to allege that the appointed assessor is answerable to the insured applicant's lawyer must be viewed with suspicion because the insurer and the insured are the only two parties to the SABS application. In this process, the IME assessor is no more compelled by law to respond to a lawyer than any expert witness. Invocations of collateral duties, such as that of an electronic-records custodian, or as between the assessor and the "patient" or "client," lack legitimate legal purpose in the SABS context.

The Ontario lawyer consulted by an assessor, assessment company or insurer to respond to these tactics must therefore first determine whether the inquiry actually raises a legitimate line of inquiry. "What is the legal basis for the request?" must be the first question the lawyer must address. If there is no legitimacy to the inquiry, the lawyer must assist the client to craft a response that clarifies the respondent's position as not being required to answer, and which explains succinctly the basis for that position. Invariably, correspondence between adverse lawyers will

not end there. In fact, the purpose of the inquiry might also be to provoke an intemperate and aggressive response, to be used as evidence that the insurer or IME assessor is acting in bad faith or as an inappropriate adversary in what must be an impartial process. Lawyers receiving such provocations should refrain from responding in kind. Since the most appropriate response to any professional correspondence is to employ utmost civility, a measured yet firm legal response is bound to be the one that frustrates the most abusive attempts to circumvent the SABS process and will provide the client with the best opportunity to achieve a good outcome. A response that correctly follows the law and navigates the gaps among SABS, PIPEDA and RHPA will have the best chance of preserving the integrity of the s. 44 process and the assessor's professional record.

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