Dr. Jason Mazzarella
DC, DAAPM, DCAPM, DAAETS, DQEEG (c), DWTT (D), FIAMA, MVC-FRA, CATSM, CBIS, CMVT, CPM, CDRSC, CDAAC, BSc Kin, BSc HPA

"Trust the doctors who teach other doctors how to
Assess, Diagnose and Treat Whiplash, Concussion and Chronic Pain Injuries."

Complainant:
Dr. Jason Mazzarella, Chiropractor
[redacted]
info@TorontoPainDoctor.com

Pages: 67

Respondents:

- [redacted]@aviva.com

Date of Complaint: August 20, 2025

Hello[redacted], how are you?

I would like to file a formal complaint regarding your conduct in adjudicating this file. You have a duty to your insured to act fairly, you also have a duty to act fairly according to the courts, and in my opinion you have not.

- **Regulated Health Professions Act, 1991**

  The Regulated Health Professions Act, 1991 recognizes chiropractors and medical doctors as autonomous professions with no statutory hierarchy, RHPA (1991), Section 33(2.1). The Respondents imposition of a fictitious hierarchy using surgeons to determine the need of a physical medicine treatment plan contradicts this legal framework. In addition, the suggestion of a fictitious hierarchy coincides with Defamatory Conduct through subtly undermining of the chiropractic profession and status, supporting a causal link to reputational harm (Wal-Mart Stores, Inc. v. Lee, 348 Ark. 707, 2002).

- **Duty of Good Faith**

  Under Non-Marine Underwriters, Lloyd's of London v. Scalera, 2000 SCC 24, The Respondents ***must act in good faith, giving equal consideration to the insured's interests***. The Respondents reliance on deceptive, cost-driven tactics breaches this duty.

  It is also a form of Indirect Discrimination Against Disabled Persons by restricting chiropractic care— which has been proven effective for whiplash (VHA Directive 1210, 2018).

  By unjustly denying appropriate care, the Respondent is forcing a disabled policyholder into less effective, cost-driven treatments that are provided by OHIP, violating their right to equal health service access under the Code which mirror Allstate's bad faith, prioritizing profit over policyholders' health.

Case Law Supporting Equal Valuation of Non-MD Providers

- Shea v. Manitoba Public Insurance Corp.
- Usanovic v. Penncorp Life Insurance Co.
  These cases highlight the dangers of insurer reliance solely on medical doctors to evaluate treatment plans outside their scope.
- Ontario (Health) v. Association of Ontario Midwives, 2022 ONCA 458
  Supports the concept of systemic discrimination based on profession.

The Respondent also Ignored my specific expertise in this matter, including my unique accreditation to teach whiplash traumatology, assessment, diagnosis and treatment across 29 countries, exemplifying bad faith.

Impact on Disabled Persons

- Denial of Pain Management: Disabled persons are denied access to chiropractic care, a primary treatment for whiplash and chronic pain which violates the Respondents Duty of Good Faith: Insurers must act fairly, as affirmed in Non-Marine Underwriters, Lloyd's of London v. Scalera (2000 SCC 24).
- Increased Suffering: This forces reliance on less effective or invasive treatments, violating their human rights.
    - Forced Reliance on OHIP: By capping benefits through the use of a medical opinion (MD) over a Chiropractic opinion (DC), The Respondents push over 95% of injured Ontarians (approximately 700,000 since 2015, 1.4 million since 2010) into an OHIP system ill-equipped for pain management which increases insured suffering.
    - Ignoring Expertise: My unique accreditation to teach whiplash traumatology and chronic pain treatment across 29 countries was disregarded, exemplifying bad faith. This systemic impact, akin to the nationwide misconduct in Campbell, justifies a punitive damage complaint by the patient as noted below.
        - Punitive Damages
            - Campbell v. State Farm: Upheld a 145:1 ratio for egregious, nationwide deceptive practices.
            - Application: The Respondent's systemic discrimination against chiropractors, impacting millions of Ontarians, mirrors Campbell. Applying this ratio to $1,947,832.59 yields $282,435,726.00 in punitive damages.
                - Total Damages based on previous Case Law.
                - Compensatory: $1,947,832.59
                - Punitive: $282,435,726.00
                - Total: $284,383,558.59 (USD)

Scope of Practice Comparison

A. Chiropractors and medical doctors are both primary care providers for musculoskeletal injuries under the Regulated Health Professions Act, 1991. No legal hierarchy exists, yet the Insurers' practices suggest otherwise.

B. Whiplash and Chronic Pain Research

Extensive research supports chiropractic care's efficacy for whiplash and chronic pain, undermining the Insurers' reliance on outdated, cost-focused guidelines or recommendations such as "participation in activities of daily living should be viewed as a therapeutic means to improve/maintain functional tolerance, mobility, range of motion and strength", page 14, report dated August 7, 2025, b[redacted]

- **Cherry-picking evidence** – There's no high-quality research showing that simply performing ADLs is sufficient therapy for whiplash, concussion, chronic pain, or complex musculoskeletal injuries. On the contrary, most clinical guidelines (e.g., Ontario *Minor Injury Guideline*, NICE guidelines, WHO rehab standards) recommend structured, progressive therapy, not just living life.
- Deceptive substitution – The statement suggests that ADLs replace treatment, but ADLs are at best maintenance, not rehabilitation. Saying otherwise misleads adjusters, patients, and courts.
- Conflict of interest – Insurer-hired doctors often reuse this line to systematically deny care, even though they know it contradicts standard of practice. That can be seen as bad faith reporting.
- Legal fraud angle – Under the Statutory Accident Benefits Schedule (SABS) in Ontario, an assessor completing a report is supposed to give an independent, evidence-based opinion within their scope. If they insert a boilerplate statement not supported by evidence or specific to the claimant, they may be:
    - Misrepresenting the clinical standard,
    - Overstepping scope (e.g., orthopedic surgeons opining on rehab, psychology, chiropractic, etc.),
    - Potentially violating Form 53 (expert declaration) obligations if testifying in court.
- ***Please have Dr[redacted] provide high quality, peer reviewed evidence that supports that typical ADL's are better for Whiplash Traumatology and Chronic Pain Rehabilitation rather than a structured in person rehabilitation program.***
- ***Please have Dr[redacted] sign a Form 53, explicating stating that he is an expert in the fields of Whiplash Traumatology, Chronic Pain (conditions the insured has), as well as Chiropractic, Acupuncture, Rehabilitation, Exercise Prescription and Active Rehabilitation as this was the requested benefits on the OCF 18 Treatment Plan.***

C. The Distinction Between Chiropractic and Medical Professions, the Absence of a Medical Hierarchy, and Insurers' Use of a Fictitious Hierarchy for Cost Reduction

The chiropractic and medical professions play vital roles in healthcare but diverge significantly in their philosophies, training, and methods of treatment. Despite their equal legal recognition under Ontario law, insurers have constructed a fictitious hierarchy that prioritizes medical doctors (MDs) over chiropractors, particularly in auto insurance claims. This practice, which echoes the systemic biases addressed in AMA v. Wilks, is designed to minimize claim costs rather than ensure optimal patient care. Below, we explore these differences, the absence of a legal hierarchy, and the insurers' cost-driven motives.

- Why the Chiropractic and Medical Professions Differ

  The chiropractic and medical professions differ fundamentally in their approaches to health and their specialized training, reflecting distinct but complementary roles in patient care. ***Dr[redacted] states multiple times in his report, "from an Orthopaedic Perspective". When an orthopaedic surgeon says they're giving an opinion only from an "orthopaedic perspective," it means they're only looking at bones and joints — not the bigger picture of pain, disability, or rehab needs, specifically what the requested OCF 18 Benefits requested on the OCF 18 Treatment and Assessment Plan. They do this to stay in their lane legally and professionally, but in the insurance world it also serves to downplay the injury and limit benefit entitlement, which in my opinion is Fraud.***

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Limiting an assessment to an “orthopaedic perspective” does not provide a complete or accurate evaluation of an individual with whiplash and chronic pain. Orthopaedic surgery focuses on structural pathology of bones, joints, and soft tissues, yet whiplash injuries and chronic pain syndromes involve neuromuscular dysfunction, altered pain processing, proprioceptive deficits, and psychosocial disability that extend well beyond structural orthopaedics. By restricting their opinion in this way, the assessor avoids commenting on the very mechanisms that sustain impairment, which means the report is inherently incomplete. Current evidence-based guidelines, including the OPTIMa Collaboration and the Bone & Joint Decade Task Force on Neck Pain, emphasize that management of whiplash and chronic pain requires a multidisciplinary perspective, including functional rehabilitation, pain modulation, and psychosocial support. Thus, while an orthopaedic perspective may rule out surgical pathology, it cannot be relied upon to determine overall disability or treatment necessity, especially treatments that fall out of their scope of practice, and their opinions should not be used to limit access to reasonable and necessary care.

- Chiropractic Profession:

  Holistic Philosophy: Chiropractors focus on the body’s inherent ability to heal, emphasizing the spine, nervous system, and musculoskeletal system. They employ non-invasive, manual techniques, such as spinal adjustments, to treat conditions like whiplash and chronic pain and look at how the body functions as a complete unit in order to diagnosis impairment.

  Specialized Training: Chiropractors complete approximately 5,000 hours of rigorous academic and clinical education, with a strong emphasis on spinal biomechanics and functional assessments. This expertise aligns with their authority under the Regulated Health Professions Act, 1991 to address complex injuries like Traumatic Cervical Syndrome (whiplash).

- Medical Profession:

  Reductionist Approach: MDs typically target specific diseases or systems, relying on pharmacological treatments or surgical interventions. Their training, while comprehensive, focuses less on manual therapies or spinal biomechanics.

  Scope Limitations: For conditions like whiplash and chronic pain, which involve intricate spinal and nervous system interactions, MDs may lack the depth of specialized knowledge that chiropractors possess. In fact, the Ontario Orthopaedic Surgeon’s association has stated that Whiplash Injuries are ‘outside the scope of its members.’

  See Appendix A.

These differences highlight distinct professional strengths, not a superiority of one over the other. Both professions are essential, addressing healthcare needs through their unique lenses.

- Why There Is No Medical Hierarchy: Under Ontario law, there is no legal basis for a hierarchy between chiropractors and MDs, as both are recognized as autonomous healthcare providers.

- Equal Legal Standing: The Regulated Health Professions Act, 1991 governs both professions, granting them authority within their respective scopes of practice without subordinating one to the other. No statute mandates medical oversight of chiropractic care.

- Judicial Insight from AMA v. Wilks: In AMA v. Wilks (526 U.S. 137, 1999), the U.S. Supreme Court ruled against the American Medical Association’s efforts to marginalize chiropractors, finding such actions violated antitrust laws. Though not binding in Canada, this precedent reinforces that professional hierarchies lack legitimacy unless explicitly legislated.

- Ontario Human Rights Code: This legislation prohibits discrimination based on occupation, ensuring chiropractors receive equal treatment in contexts like insurance claims processing.

The absence of a statutory or judicial hierarchy confirms that any imposed ranking is artificial and unjustified.

- Why Insurers Use a Fictitious Hierarchy to Reduce Claim Costs: Insurers exploit this lack of hierarchy by creating a fictitious one, prioritizing MDs over chiropractors to cut costs, often to the detriment of policyholders' health.
- Cost Reduction Motive: Chiropractic care, while effective for conditions like whiplash and chronic pain, can be more expensive than pharmaceutical alternatives favored by MDs, especially in a government driven medical system that costs can be deferred to. Insurers impose a hierarchy to favor cheaper, less specialized treatments that can be funded by taxpayers, allowing for higher quarterly profits.
- Claims Handling Tactics:

  MD Approval Requirements: Insurers often demand MD oversight for chiropractic treatment plans, despite MDs' limited training in spinal injuries, leading to delays or denials of care.

  Minor Injury Guideline (MIG): This framework caps benefits at $3,500 for "minor injuries," relying on outdated, insurer-influenced studies like the Quebec Task Force, which prioritized cost containment over clinical evidence.

  Financial Gains: Historical examples, such as Allstate's Colossus system in the 1990s, demonstrate how devaluing chiropractic care reduced payouts by 20%, saving insurers millions annually. This fictitious hierarchy serves their bottom line, not patient outcomes.

By enforcing this artificial structure, insurers breach their duty of good faith, discriminating against chiropractors and limiting policyholders' access to appropriate care. This results in an Insurer's Financial Conflict of Interest.

By denying chiropractor-prescribed care and imposing the Minor Injury Guideline (MIG) cap of $3,500, insurers are able to reduce their claim exposure drastically—at times by over $45,000 per claimant, even when policy limits allow $50,000.

Treatment Cap	Claims Per Year (2019)	Total Exposure
$3,500	104,169	$364,591,500
$50,000	104,169	$5,208,450,000

This represents a potential annual savings of nearly $5 billion dollars, gained not through superior care or medical necessity, but by systemic denial based on discriminatory policy. Please see the Appendix for additional details.

REQUEST FOR IMMEDIATE RECONSIDERATION

Given the lack of evidentiary foundation and the discriminatory process used in the denial of this claim, I request immediate reconsideration of the submitted OCF-18 treatment plan. If unresolved, I will pursue formal complaints and legal action.

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Please feel free to contact this office with any questions.

Thank you,

Dr. Jason Mazzarella, DC, DAAPM, DCAPM, DAAETS, DqEEG (c), DWTT (D), FIAMA, MVC-FRA, CATSM, CBIS, CMVT, CPM, CDRSC, CDAAC, BSc Kin, BSc HPA

Doctor of Chiropractic
Director North American Spine Institute
Medical Board Member Editor: Journal of Clinical Research in Pain and Anesthesia.
Elected Board Member – Canadian Institute for the Relief of Pain and Disability 2013
International Post Graduate Developer and Educator: Medical Curriculum (CME Accreditation USA and Canada)

- Whiplash Traumatology and Treatment: A Multidisciplinary Approach to Care: 2008-2011
- Crash Forensics, Injury Biomechanics, Occupant Kinematics and the Biopsychosocial Model of Pain
- Whiplash Traumatology, Neurophysiology, Pain and Treatment Seminar Series: A Multidisciplinary Approach to Care: 2021 – Present

International Post Graduate Developer and Educator: Chiropractic Curriculum (CCE Accreditation USA, Canada and Europe)

- Whiplash Traumatology and Treatment: A Multidisciplinary Approach to Care: 2008-2011
- Whiplash Traumatology, Neurophysiology, Pain and Treatment Seminar Series: A Multidisciplinary Approach to Care: 2021 – Present
- Whiplash Injury: Guidelines and Rebuttal/IME Report Writing
- Chiropractic Treatment of Whiplash:

International Post Graduate Developer and Educator: Physical Therapy and Massage Therapy Curriculum (Accreditation USA)

- Whiplash Traumatology, Neurophysiology, Pain and Treatment Seminar Series: A Multidisciplinary Approach to Care: 2021 – Present

Graduate Certification Developer and Lecturer Accident Reconstruction

- Occupant Kinematics, Injury Biomechanics and Crash Forensics

Diplomate American Academy of Pain Management 2011 and 2016
Diplomate Canadian Academy of Pain Management 2011
Diplomate American Academy of Experts in Traumatic Stress 2010
Diplomate Quantitative Electroencephalogram -qEEG (C) 2021
Diplomate Whiplash Traumatology and Treatment (D) 2022
Fellowship International Academy of Medical Acupuncture 2006
Registered Acupuncturist CTCMPAO 2014
Certification Motor Vehicle Trauma 2011
Certification Pain Management 2010
Certification Acute Traumatic Stress Management 2011
Certification Motor Vehicle Crash – Forensics Risk Analysis 2006
Certification Brain Injury 2009
Certificate Whiplash and Brain Traumatology 2005
Advanced Certificate of Competency Whiplash and Brain Traumatology 2011
NBCE Certified Physiotherapy Competency 2005
BSc. Kinesiology Movement Science 2001
BSc. Health Policy and Administration 2001
Crash Data Retrieval System Operators (Technician) Certification 2012
Crash Data Analysis and Application Certification 2013
Certification Accident Investigation 2011
Certification Accident Investigation and Reconstruction Level 2 2012
Certification Accident Investigation and Reconstruction Level 3 2013

- **Whiplash Education and Training for Healthcare Professionals:**
- **Academic Accreditation and/or Endorsement partners for both Whiplash Programs shown below**

- **Dr. Jason Mazzarella, DC**
  - Whiplash Traumatology & Treatment: A Multidisciplinary Approach to Care.
    - 108 Medical, Chiropractic and AAFP Continuing Education Credit Hours
  - Whiplash Traumatology, Neurophysiology, Pain and Treatment Seminar Series: A Multidisciplinary Approach to Care.
    - 32 Medical, Chiropractic, Physical Therapy, and Massage therapy Continuing Education Credit Hours

American Chiropractic Association

American Academy of Family Physicians

European Chiropractors' Union

National University Of Health Sciences

Jacobs School of Medicine and Biomedical Sciences University at Buffalo

Northeast College of Health Sciences

College of Osteopathic Medicine
Continuing Medical Education

McMaster University | HEALTH SCIENCES Continuing Professional Development

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Appendix A: Insurance Systemic Discrimination

Insurance Systemic Discrimination

Insurers have developed policies and procedures that have been incorporated into the insurance culture to devalue Chiropractic Care (Alternative Medicine Therapies) and opinion in lieu of Medical Care (Pharmacological / Surgical) and opinion, specifically designed and based on cost containment strategies first developed in the United States in the 1990's.

This culture of Systemic Discrimination is systematically designed to devalue Chiropractors, as Chiropractors are the primary specialists treating and assessing Whiplash and Chronic Pain Injuries. By implementing this type of policy and procedure, specifically designed to Systemically Discriminates against Chiropractic, the insurer can deny warranted benefits to those injured through the facade of legitimate claims handling, pushing the costs of healthcare for nearly 70,000 Ontarians a year (based on Canadian statistics) onto the publicly funded OHIP system.

Understanding Systemic Discrimination Human Rights/Canadian Charter Violations:

Systemic Discrimination:
Ontario Human rights Commission:

1. "Systemic discrimination is discrimination that is part of the social or administrative structures of many organizations, whether a business, service organization or social institution, such as a school, hospital, government office, law court, etc. Systemic discrimination can be found in an organization's **policies or practices**, and it may be invisible. Even if unintended, it **can deny whole groups of people their rights or exclude them from taking part**."
2. Biases against groups may mean that they are treated differently.

Systemic Discrimination has been defined as "practices or attitudes that have, whether by design or impact, the effect of limiting an individual's or a group's right to the opportunities generally available because of attributed rather than actual characteristics. (Canadian National Railway Co. v. Canada (Canadian Human Rights Commission), [1987] 1 S.C.R. 1114 at p. 1138)

The suggestion that a Medical Doctor can override or supersede a Chiropractic Doctors opinion specifically related to a chiropractic treatment plan is a designed policy and practice based on discrimination for the sole purpose of cost containment and is not found in any governing laws.

1. Regulated Health Professions Act, 1991, S.O. 1991, c. 18 (no hierarchy noted)
2. Statutory Accident Benefits Schedule, O Reg 34/10 (no hierarchy noted)
3. The Drugless Practitioners Act, 1929, SS 1928-29, c 56
4. Health Disciplines Act, RSA 2000, c H-2
5. Wilk v. American Medical Association, 895 F.2d 352 (7th Cir. 1990)

This same deceptive tactic has been used by auto insurers in the United States since the early 1990's. Allstate Insurance Company was found liable in an Arkansas Supreme Court based on this specific type of claims handling process, which was considered a deliberate attempt to harm a non-medical doctor healthcare provider for profit. Based on this deliberate attempt to harm, the court awarded the non-medical doctor healthcare provider $6 million dollars in compensatory damages and $15 million dollars in punitive damages. (376 S.W.3d 414 (Ark. 2011), 10-257, Allstate Ins. Co. v. Dodson)

This is even alluded to by the insurers OWN doctor. In the report dated August 7, 2025, by Dr. [redacted], the doctor states, the treatment plan is musculoskeletal in nature and not related to the doctors scope of practice as an otolaryngologist.

5. Notwithstanding your responses to questions 3 & 4, is the proposed Treatment and Assessment Plan (OCF-18) reasonable and necessary as related to the impairments from the motor vehicle accident? Please explain why or why not.

As the proposed treatment is musculoskeletal in nature, and not related to the otovestibular system, my ability to comment is limited and deferred to the appropriate specialist. I would add, however, that improvement in pain symptoms has the ability to lessen tinnitus burden in some patients.

Claims Handling

Like all other personal injury claims handling in Canada and the United States, claim processing in Ontario requires an onus on the adjuster to act in Good Faith and fair dealings in their duty to act both promptly and fairly when adjudicating a file. As outlined in case law, during this process, the insurer is bound to afford equal interest to the insured as their own (Non-Marine Underwriters, Lloyd's of London v. Scalera, 2000 SCC 24 (CanLII), [2000] 1 SCR 551) and (Kardaras v. Sun Life Assurance Company of Canada, 2020 ONSC 392)

The insurer has a fiduciary duty to protect their insured, and when they Systemically Discriminate against Chiropractic, they fail this fiduciary duty by failing to offer the full value of a claim to the injured party. By intentionally denying or underpaying claims, insurers can decrease insurance premiums, which allows them to capture more market share for people looking for the least expensive insurance rate, and we have seen this time and time again in the past, only to repeat itself today using the same policies and principles enacted in the 1990's that were described by the courts as systemic bad faith. These costs then are placed on the publicly funded OHIP system, as well as the publicly funded assistance programs that all taxpayers pay for. This Systemic Discrimination against Chiropractic does not only hurt Chiropractors, but it also hurts everyone that pay taxes in Ontario!

Specific Considerations

1. The Minor Injury Guideline is unconstitutional
    a. Abyan v. Financial Services Commission of Ontario, 2019 ONSC 7247 (CanLII).
2. Aviva funded the Enabling Recovery from common Traffic injuries: A focus on the Injured Person NAD Guideline, 2015.
    a. On page 39, the primary authors were authors from the QTF, and the primary expert panel was from Aviva Canada.
    b. On page 42, the lead authors funding including the insurance work safety board and Aviva Canada.
    c. The authors reported on page 6, "Having considered the narratives of persons who experienced injuries and received care under the MIG, ***we have concluded that it is NOT appropriate to categorize either the injuries or their associated symptoms as minor injuries***, and as much as they can be associated with a broad range of symptomology, and with some degree of disability for activities of daily life or work. It is our view that there is no scientific rationale or merit in continuing to employ the term minor injury."
3. Chronic Pain is NOT a minor Injury.
    a. 17-000835 v. Aviva General Insurance Canada, 2018 CanLII 83520 (ON LAT).
    b. Applicant v Aviva, LAT 16-001934 2017 CanLII 69464 (ON LAT).
    c. Y.X.Y. v. The Personal Insurance Company CanLII (16-000438) (ON LAT).

Background Information: Development of Deceptive Tactics intended to Systemically Discriminate against an entire profession for the sole purpose of claim cost reductions.

In 1992 Allstate Insurance Company (Allstate) started a pilot project that changed the way insurance companies in North America treat their customers, leading to record profits for the company. This policy was then adopted by Canadian Auto Insurers and is still used today to adjudicate claims. As discussed in the legal version of From Good Hands to Boxing Gloves, McKinsey & Co. consulted with Allstate Insurance, creating a pilot project called Claims Core Process Redesign ("CCPR"). This was a claim system that completely changed the auto insurance industry.

The pilot project was designed to fight injury claims by either denying injury causation or damages solely based upon the amount of vehicle damage. This defense was advanced even though there was scientific evidence and historical evidence of injuries and even deaths in minimal vehicle damage claims.

Insurers would first deny a claim based on their policies, without being specific as to the policy or rational for denial. Secondly, the claim was sent to a medical specialist intentionally to reduce the likelihood of the claim being seen as warranted and necessary, and third, the settlement of the dispute was then intentionally delayed resulting in a hardship to the insured.

Throughout the 1990's this policy was practiced, and eventually was considered Institutional Bad Faith by the United States Supreme courts. However, during that time span, insures profited to the tune of over 700 million dollars. This is the same policy and procedure the auto insurer is currently using to adjudicate claims in Ontario, even though it is well understood and known that the courts consider this form of claims handling "Systemic Bad Faith".

Systemic Discrimination: History.

- In the early 1990's Allstate Insurance Company (Allstate) saw soft tissues injuries as Fraud. Their rational was that Neck Sprain/Strains were costing insurers nearly $29 billion dollars per year, whereas a Hamstring Sprain/Strain would recovery and resolve on its own within 3 weeks.
    - Schmid P: [Whiplash-associated disorders] Review. 1999 Sep 25;129(38):1368-80.
- To reduce claim costs, Allstate hired McKinsey Company out of New York City to revamp their claims handling policy and procedures. McKinsey Company adopted two primary practices. They developed a Guideline called MIST, Minor Impact Soft Tissue Trauma and implemented a claims handling computer system called Colossus.
    - This is what our current Minor Injury Guideline is based off of.
- As part of the MIST program, adjusters were instructed to Deny, Delay, and then Defend claims. This was intentionally developed and designed to prevent those injured from obtaining warranted benefits as they would not be able to afford the litigation process.
- However, eventually some of these denied auto claims were litigated. As Allstate had no medical evidence to support the denial of benefits, and on the recommendation of McKinsey Company, they then contracted a company called "Minorpac", owned by two insurance defense doctors, who alleged that there were mathematical equations that could support the idea that minimal vehicle damage could not result in occupant injury.
- Minorpac's equations were considered nonsensical and demonstrates that the "minor impact" defense was always intended to intentionally underpay claims by misleading judges, jurors and even Allstate's own insurance adjustors with junk science.
- Despite this, Allstate adopted the "Minor Impact Soft Tissue" or "MIST" defense in cases - either making a very lowball offer to settle a claim, typically which would not cover the total cost of treatment incurred by the insured or simply pushed the case to trial. They did this through two specific policies and practices.
    - Development of a Fictious Medical Hierarchy (which we see has occurred in this claim)
    - Development of an SIU unit, suggesting low impact collisions were fraudulent and supporting this with Biomechanist's testimony.
- Allstate's development of a Medical Hierarchy.

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- A report by the Insurance Research Council showed that Chiropractic Care/Physical Medicine Care was significantly more expensive than Medical Care/Pharmacological Care. The council reviewed 70,000 auto injury claims from insurers country wide to reveal why medical costs were escalating. The emerging trend was that sprain/strain injuries were increasing while serious auto injuries were decreasing. This coincided with the National Traffic Highway Safety Administration 5-star crash testing that started in the late 1990's, which made cars more plastic, increasing the elastic component of the collision and helping to reduce overall insurer BI claim exposure.

- Insurance Research Council Findings:

Doctor	Claim % Treated With Attorney	Claim % Treated Without Attorney	Claim Average # visits with Attorney	Claim Average # visits without Attorney	Total Cost With Attorney	Total Cost Without Attorney
GP-Medical	39%	39%	5	2.4	$838	$272
Neurologist	6%	1%	2.8	3.0	$1,069	$965
Orthopedist	11%	3%	4.7	3.7	$1,191	$746
Chiropractor	**64%**	**37%**	**25.9**	**18.3**	**$3,047**	**$1,803**
Physical Therapist	30%	13%	17.5	10.8	$,2340	$1,447

- IRC Study, Auto Injury Insurance Claims: Countrywide Patterns in Treatment, Cost and Compensation. Insurance Research Council
- ***Allstate then implemented a Medical Hierarchy through their claims computer system, Colossus.***
- Colossus recognizes three physician categories. DC (Doctor of Chiropractic), MD (Doctor of Medicine), DO (Doctor of Osteopathy). Though they recognized three physician groups, DC's were required to be "bookend" by MD's for services to provide claim value as the program was originally developed in Australia at a time where Chiropractic was not full recognized by the Government. In this way, they devalued Chiropractic care if it was not recommended by a Medical Doctor. This systemic discrimination has been found to result in significant claims savings as I will show later in this document.
- This tactic was designed to reduce physical medicine claims in favour of pharmaceutical claims which were more cost effective for insurers. This was demonstrated through Osteopathic Doctors (DO) treatment value determinations in Colossus. If the DO performed a spinal manipulation, Colossus provided minimal to no claim value for that treatment. However, if the DO prescribed medication, Colossus provided increased settlement claim value for that treatment.
- **This was an intentional deceptive act designed to reduce claim costs and was implemented by having medical doctors review chiropractic doctors' treatment needs, on conjecture that a medical hierarchy exists with Surgeon at the top, followed by medical specialists, medical family doctors and finally Chiropractors at the bottom.**
- Due to this deceptive Act (usage of Colossus to adjudicate claims), the Florida Office of Insurance Regulation the Department of Insurance requested an immediate suspension of Allstate's (USA) Certificate of Authority to transact new insurance business in Florida. The request made by the Department of Insurance was for production of "the McKinesy Documents" regarding Allstate's claims handling. Their intent was to address allegations of Allstate using a computer program which "immediately reduce [s] the size of bodily injury claims by up to 20%. Any insurer who buys a license to this program can calibrate the amount of "savings" it wants the program to meet. If the program does not generate "savings" to meet the insurer's goals, the insurer "adjusts" the benchmark values until the program reaches the desired results. The allegations state the "program is designed to systematically reduce payments to policyholders without adequately examining the validity of each individual claim." The findings of this court ruling stated that based on Allstate's conduct, the Department of Insurance complied with section 120.60(6), Florida Statues and was allowed to temporarily suspend Allstate's ability to transact new insurance business.

    - District Court of Appeal First District, State of Florida, Allstate v. Office of Insurance Regulations. Case No 1D08-0275

- By using Surgeons and Medical Specialists in lieu of Chiropractic Doctors, which are the primary medical functional spine specialists, and primary doctors treating whiplash and chronic pain patients, the insurers were able to use well educated and well-respected doctors that had no understanding or training in whiplash, but which gave the perception of a bona fide proper examination which then allowed for Systemic Discrimination of Chiropractic in plane sight. I will describe this in detail under the
  "Scope" section of this report.
    - Jeffrey D. Bohn Esq. Value Drivers in Personal Injury: Value Drivers in Personal Injury by Jeffrey D. Bohn (slideshare.net)
- The ideology presented here and employed by Allstate in the 1990's is relevant, as the auto insurer is using the same systemic discriminatory practices and principles designed and utilized by Colossus to adjudicate Ontario claims.

MIST Defense: (What the Ontario Minor Injury Guideline was developed from and is based off of.)

- The intent of the MIST defense was to make claims so expensive for plaintiffs and their lawyers that it didn't make financial sense to fight injury claims where there was little visible vehicle damage. The decision to defend these cases at any cost was to disincentivize injured people from making a claim by claiming they were greedy people faking injuries to hit the "lawsuit lottery," and disincentivizing lawyers from taking these cases by making them unreasonably expensive and financially dangerous to accept.
- Over time, many lawyers quit accepting claims with minimal vehicle damage (MIG claims), leaving injured people without legal counsel. In some cases, insurers disincentivized doctors from treating these injured people by claiming that the doctor was engaging in fraud and launching Special Investigations Unit raids in doctors' offices.
- **By challenging my scope of practice, and using surgeons to adjudicate a chiropractic treatment plan, the insurer is acting in a Systemic Discriminatory manor that resembles the same attitudes and deceptive acts that Allstate employed in the 1990's and includes:**
    - **Using a Medical Specialist to determine the need of a Chiropractic Treatment Plan**
    - Using outdated ideology of Whiplash Injury – Soft Tissue Injury vs. Traumatic Cervical Syndrome.

Breakdown of Insurance Profits based on Systemic Discrimination of Chiropractic:

- In 1994, the year before Colossus was implemented, Allstate Insurance paid out 65.9 cents in auto-injury claims for every $1 in premiums collected, according to A.M. Best, which tracks the insurance industry.
- That rate fell steadily to 51.7 cents in 1998.
- That year, Allstate's then-chairman, Jerry Choate, said in an internal company magazine the changes had helped lower bodily injury payouts by 17.5% during a three-year period. "That's worth $200 million a year to Allstate," he noted.
- After multiple lawsuits the claim cost rose to 61.2 cents, still an industry best.
- In comparison, State Farm Mutual Insurance Company, at the time the No. 1 auto insurer in the United States, which reported that it does not use Colossus, or any similar program paid out 83.2cents on each $1 of premiums in 2001, up from 70.7 cents in 1994.
- So, the implementation of this program allowed Allstate to pay 51.7 cents per premium dollars collected vs an industry standard of 83.2 cents per premium dollar collected. This was an average savings of 32 cents per premium dollar collected.

Citations:

1. Guidera J: Colossu at the accident scene: software of insurers spurs suits. Dow Jones and Company 2021.
2. Schmid P. Whiplash-associated disorders [Whiplash-associated disorders]. Schweiz Med Wochenschr. 1999 Sep 25;129(38):1368-80. German. PMID: 10536802.
3. District Court of Appeal First District, State of Florida, Allstate v. Office of Insurance Regulations. Case No 1D08-0275
4. RSO 1990, c I.8 _ Insurance Act _ CanLII
5. O Reg 7_00 _ Unfair or Deceptive Acts or Practices _ CanLII
6. 2017 ONCA 395 (CanLII) _ Usanovic v. Penncorp Life Insurance Company (La Capitale Financial Security Insurance Company) _ CanLII
7. Wallstreet Journal 'Colossus' at the Accident Scene_ Software of Insurers Spurs Suits – WSJ
8. Freeman MD, Croft AC, Rossignol AM, et al: A review and methodologic critique of the literature refuting whiplash syndrome. Spine 24:86-98, 1999
9. Jeffrey D. Bohn Esq. Value Drivers in Personal Injury: Value Drivers in Personal Injury by Jeffrey D. Bohn (slideshare.net)

United States Litigation: Systemic Discrimination

In 2011, The Arkansas Supreme Court stated, “In litigation spanning 15 years, the Arkansas Supreme Court found in Allstate Insurance Company v. Dodson, that Allstate adopted dishonest auto claims handling practices.” In testimony during this trail, evidence was provided that stated Allstate’s national practice was to utilize a computer program (Colossus) to calculate a range of settlement values for claims involving minor impact, soft-tissue injuries and make settlement offers in the lowest ten percent of that range.” Part of this program was the introduction of Minor Impact Soft Tissue Treatment (MIST) guidelines. (376 S.W.3d 414 (Ark. 2011), 10-257, Allstate Ins. Co. v. Dodson)

The courts stated MIST worked in two primary ways.

- First the claim would be denied on an arbitrary basis or policy, like the MIG limits which we have in Ontario today reducing $50,000.00 of medical and rehabilitation benefits to $3,500.00.
- Next the auto insurer would delay claim processing and settlement, by sending the insured to multiple Independent Medical Examinations with medical specialists that were costly to impose financial hardship on plaintiff attorneys and accident victims.
    - [redacted] **initially even scheduled the insured with a doctor that had been retired for several years and no longer even had a scope of practice in Ontario.**
    - Dr[redacted], and describes Dr[redacted] as a “Vestibular Specialist”.

Assessment type (e.g. Occupational Therapy In-Home, Physician Examination, Psychological Examination, FAE, etc.)	Audiology and Vestibular testing
Assessor’s name and discipline	Dr[redacted] Vestibular Specialist
Appointment Date	Monday, June 16, 2025 **Time:** 10:45 AM
Average Duration of Appointment	1 hours, 30 minutes
Location of Appointment	2145 Dunwin Drive, Unit 9, Mississauga, ON, L5L 4L9
Transportation	**Not scheduled – if required, please contact us immediately.**
Interpretation	**Not scheduled – if required, please contact us immediately and confirm the language**

    - The respondent is using a previous medical doctor that has NO SCOPE of Practice and NO indication that they have any specific vestibular training as per the CPSO website.

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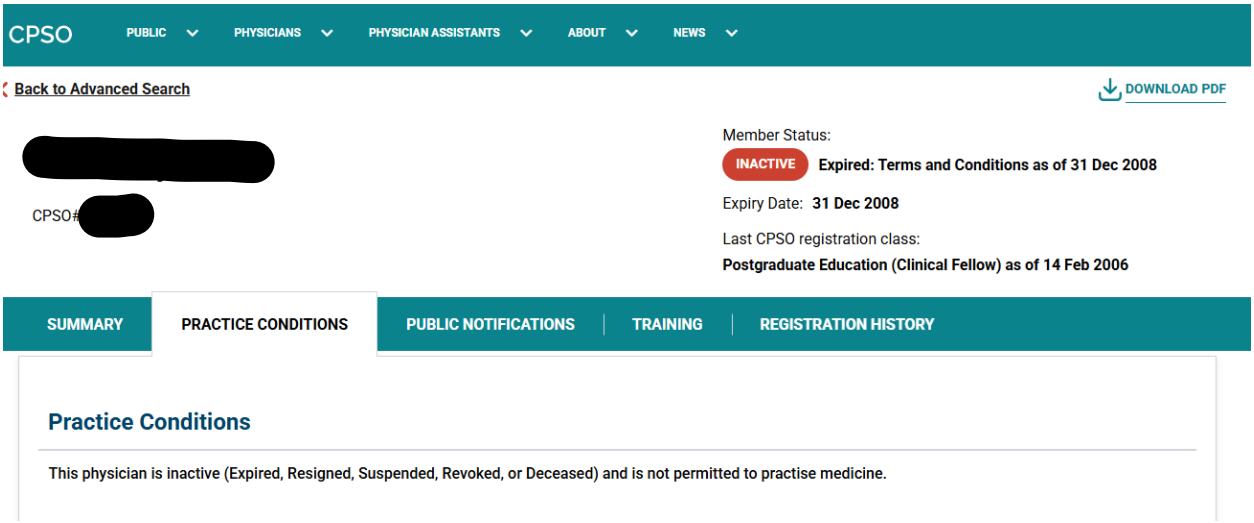

As I will show, this form of Systemic Discrimination infers that Chiropractors are second tier doctors or therapists whose opinions are superseded by Medical Doctors due to a hierarchy that does not exist in the Regulated Health Professions Act, 1991, S.O. 1991, c. 18, for the specific and calculated undertaking of claims cost reduction at the expense of an entire health profession which establishes a causal connection of defamation and should allow for punitive damages if the insurers continue to go down this avenue of claims handling.

- Case for defamation, there must be evidence that establishes a causal connection between the defamatory statements and the injury suffered by the plaintiff.
    - See Wal-Mart Stores, Inc. v. Lee, 348 Ark. 707, 738, 74 S.W.3d 634, 655 (2002).
- As the adjuster referred a Chiropractic Treatment Plan to a Medical Specialist, this is a subtle and deceptive tactic with intent to devalue a Chiropractic opinion for financial gain. This casual connection by minimizing and devaluing Chiropractic specific to Whiplash Injuries is defamation as there is no legal precedent stating a Medical Hierarchy exists.

How this relates to Claim Handling in Ontario:

In Ontario, auto insurers have a policy and practice in place to adjudicate claims based on a hierarchy of medicine. Such that Surgeon opinions are given greatest weight in a whiplash and chronic pain injury case, followed by medical specialists, medical doctors, and then finally chiropractors. This concept of medical hierarchy was one of the founding principles of colossus. In colossus the system would intentionally provide no claim value for treatments provided by Chiropractors while providing the greatest claim value for treatments provided by medical specialists and surgeons based on cost containment strategies as shown above.

This was a way to reduce overall claim costs at the insured's expense in plane site. In addition, auto insurers use an Arbitrary Guideline, the Minor Injury Guideline (MIG) to determine physical medicine treatment need. This MIG guideline was developed and based off of recommendations set forth by the Quebec Task Force on Whiplash Associated Disorder Guidelines and then reconfirmed in 2014 by recommendations set forth by the FSCO funded Enabling Recovery From Common Traffic Injuries: A Focus on the Injured Person NAD. This program, MIG, that started in 2010 was first introduced through misrepresentation of the scientific literature in a concerted effort to reduce claim costs. As per section 18.2 of the Statutory Accident Benefits Schedule (SABs), a MIG injury was monetary capped at $3,500.00, whereas non-MIG injuries had up to $50,000.00 of medical rehabilitation benefits.

According to the SABs,

- “whiplash injury” means an injury that occurs to a person’s neck following a sudden acceleration deceleration force. (“coup de fouet cervical”) O. Reg. 34/10, s. 3 (1); O. Reg. 289/10, s. 1 (1); O. Reg. 251/15, s. 2 (1); O. Reg. 123/19, s. 1 (1-4).
- “whiplash associated disorder” means a whiplash injury that,
    - (a) does not exhibit objective, demonstrable, definable and clinically relevant neurological signs, and
    - (b) does not exhibit a fracture in or dislocation of the spine; (“entorse cervicale”)
- ““sprain” means an injury to one or more tendons or ligaments or to one or more of each, including a partial but not a complete tear; (“entorse”)
- “strain” means an injury to one or more muscles, including a partial but not a complete tear; (“foulure”)
- “subluxation” means a partial but not a complete dislocation of a joint; (“subluxation”)
    - Statutory Accident Benefits Schedule, O Reg 34/10

The SABs definition of Whiplash Injury, whiplash associated disorder, sprain, strain and subluxation comes from the Quebec Task Force on Whiplash Associated Disorders.

Legal Statement: Distinction Between Chiropractic Subluxation and Medical Subluxation under the SABS

It is submitted that a *chiropractic subluxation* is fundamentally distinct from a *medical subluxation* as defined within the Statutory Accident Benefits Schedule (SABS), O. Reg. 34/10. The SABS adopts the Quebec Task Force definitions of "subluxation" as a partial but not a complete dislocation of a joint, which is an anatomical diagnosis derived from radiographic or surgical findings.

Conversely, in chiropractic clinical practice, the term subluxation refers to a functional and/or structural lesion or biomechanical dysfunction in a joint or motion segment, which may influence neural integrity and physiological function. This definition, grounded in neuromusculoskeletal assessment and manual diagnostic procedures, does not require radiographic confirmation of joint displacement and does not imply partial joint dislocation in the medical sense.

Therefore, chiropractic subluxations—being neurofunctional disorders—do not fall within the restrictive scope of "minor injuries" as defined under the Minor Injury Guideline. The MIG is intended to apply to soft tissue injuries such as sprains, strains, and medical subluxations that do not produce objective neurological impairment or structural dislocation.

Given that the chiropractic subluxation may contribute to persistent pain, functional disability, or neuromuscular impairment, it cannot be presumed to fit within the limited definitions outlined in the MIG. As such, when clinical evidence supports that the chiropractic subluxation results in chronic pain or functional loss, it should be considered an injury outside the MIG framework and eligible for treatment funding beyond the $3,500 cap.

Therefore, the OCF 18 Treatment Plan under review, and which included Chiropractic Treatment, cannot be evaluated or reviewed by a surgeon, nor can it be considered under the Minor Injury unless a Chiropractor were to have reviewed the OCF 18 Treatment Plan and suggested that no subluxation was present that required chiropractic intervention. This did not happen.

Application of Whiplash Guidelines which the Ontario Minor Injury Guideline was developed and based off of.

> “Reasonable and equitable peer review requires serious consideration of a patient's complaints and the physical and laboratory findings, along with a consideration of known risk factors and complicating features. It is scientifically, clinically, and ethically unsound to apply any practice guideline without such consideration. The consanguineous marriage of statistics and guidelines - in the vacuum of clinical information - provides nothing more than an example of a wrong question inviting an irrelevant answer.”

Arthur Croft • Croft AC: CAD Guidelines: We Have Them; Let's Use Them: Results of a Preliminary Practice Survey. Dynamic Chiropractic – November 19, 2001, Vol. 19, Issue 24

The Quebec Task Force Guidelines - Summary:

- SAAQ - Société de l'assurance automobile du Québec funded the research and publication of this guideline.
- In January 1995, the Societe de l'assurance Automobile du Quebec (SAAQ) published a text entitled, Whiplash Associated Disorders (WAD)--Redefining Whiplash and its Management (referred to, henceforth, as the "text"). The text was authored by the Quebec Task Force on Whiplash-Associated Disorders, which was chaired by Walter O. Spitzer, M.D., M.P.H., F.R.C.P.C., and consisted of an eminent panel of experts in medicine, epidemiology and biostatistics, chiropractic, and other disciplines.
- The strategy of the Task Force was to use the "pre-eminence of evidence" for developing the guidelines, and that, no matter how eminent the panel members were in their respective fields of specialty, their opinions were "always subordinate to evidence" (section 1, page 3).
- The Task Force published a 73-page pull-out supplement in the April 15, 1995, issue of the Journal Spine called the Quebec Task Force on Whiplash Associated Disorders. The following information can be found in this publication which Ontario has based their Minor Injury Guideline on.
- "The Quebec Task Force defined whiplash as an acceleration-deceleration mechanism of energy transfer to the neck which may result from rear-end or side impact, predominantly in motor vehicle collisions, but also from diving accidents, and from other mishaps.
    - This does not consider other vector (direction) collisions. Front or Offset.
- **The energy transfer may result in bony or soft tissue injuries (whiplash injury), which in turn may lead to a wide variety of clinical manifestations (whiplash-associated disorders)."**
    - **This is where Insurance Medical Doctors get the terminology "soft tissue injury" from. Not through medical research, experience or review, but rather through a Guideline with the specific intent of cost containment of physical medicine therapies.**
    - **Since 1993, medical research has shown that whiplash injuries are NOT soft tissue injuries. Whiplash Injuries are actually Cervicocephalic Kinesthetic System injuries that affect neurological and spinal structures associated with the spinal kinematics during a motor vehicle collision, combined with future spinal biomechanical changes. Which is the exact scope of practice for Chiropractors in Ontario.**
        - **Cervicocephalic Kinesthetic System**
            - This system provides **proprioceptive input** from:
                - Deep cervical muscles (e.g., longus colli, longus capitis).
                - Cervical facet joint mechanoreceptors.
                - Vestibular and visual integration centers.
            - In whiplash, injury to these structures can disrupt the system, leading to:
                - Poor head-trunk coordination.
                - Delayed or unsteady head movement (i.e., **head lag**).
                - Dizziness, disorientation, visual instability, and balance issues.
            - IME report by Dr [redacted] dated August 7, 2025.

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[redacted] has a history of hearing loss and tinitus that predate[redacted] MVC. It is very common for acute stress or pain or headaches or sleep disturbances to amplify symptoms of tinnitus. This is likely what is happening in [redacted] case considering [redacted] remains affected by lower back pain and right hip pain as reported by the claimant today. I would recommend conservative management for now and [redacted] is aware of strategies for background noise and masking and camouflage techniques for tinnitus. I did advise [redacted] that [redacted] presumed presbycusis, or age-related hearing loss should be followed in the community by [redacted] primary care practitioner and a repeat assessment of the hearing in the future would be advisable. Hearing aids could obviously be considered in the future outside the scope of this assessment today. From a vestibular perspective, [redacted] is likely having some dizziness symptoms concurrently with her headaches rather than any peripheral vestibular pathology. [redacted] clinical exam and objective vestibular test results are quite normal. No specific intervention from an ENT perspective is required at this time.

- **This is because in whiplash injury mechanism, proprioceptive fibers in the cervical spine, specifically C1 and C2 cause changes in proprioception and vestibular symptoms. Your IME doctor confirms that the insured, my patient has "dizziness symptoms with concurrent headaches." The best treatment for this is vestibular rehabilitation which was requested under the exercise request in the denied OCF 18 Treatment Plan.**

- "Whiplash-associated disorder (WAD) is the term adopted by the Quebec Task Force to describe the clinical entities associated with the energy transfer and the injury."
- "The strategy of the Task Force was to use the "pre-eminence of evidence" for developing the guidelines, and that, no matter how eminent the panel members were in their respective fields of specialty, their opinions were "always subordinate to evidence" (section 1, page 3). The strategy of the Task Force was to use the research review to support treatment need.
    - Please note in review of the 10,382 articles reviewed, 62 were deemed acceptable.
    - This led to the following "evidence-based recommendations".

• QTF

Therapy	Research Used	Recommendations
Immobilization		
Cervical Collars	No research studies used	No longer then 72 hours
Bed Rest	No research studies used	No more than 4 days
Cervical Pillows	No research studies used	Not required
Activation		
Spinal Manipulation	2 studies	Short term benefit
Mobilization	Combined Studies	Regimen can be used
Exercise	Combined Studies	ROM exercises only
Posture Advice	Combined Studies	Can be given
Spray and Stretch	No research studies used	Not recommended
Cervical Traction	Combined Studies	Can be combined with other Rx

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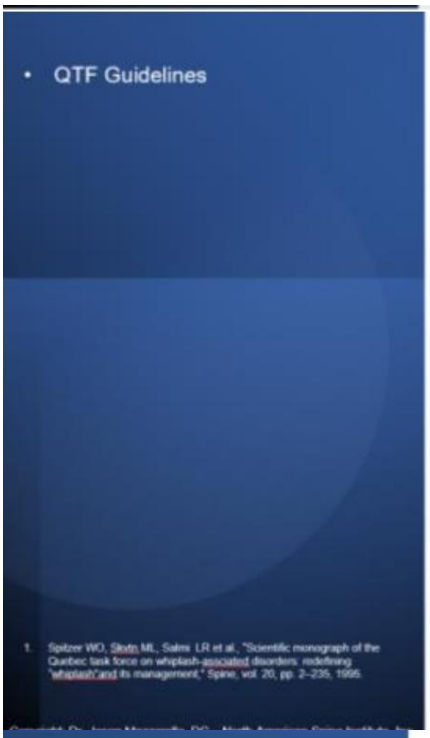
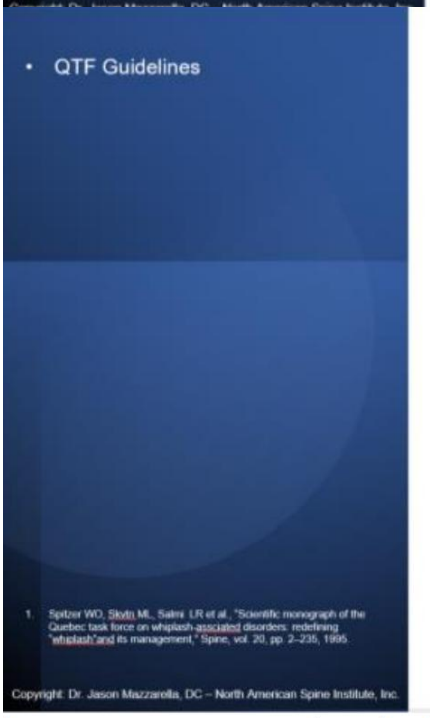


• QTF

Therapy		Research Used	Recommendations
Passive Modalities			
TENS		No research studies used	
PEMT		2 studies	**Not recommended**
Electrical Stimulation		No research studies used	**Optional activation adjunct**
Ultrasound		No research studies used	**Optional activation adjunct**
Laser		No research studies used	**Optional activation adjunct**
Short Wave Diathermy		No research studies used	**Optional activation adjunct**
Heat		No research studies used	**Optional activation adjunct**
Ice		No research studies used	**Optional activation adjunct**
Massage		No research studies used	**Optional activation adjunct**
Ultrasound		**No research studies used**	**Optional activation adjunct**



• QTF

Surgery			
Surgery		No research studies used	**Very restricted use**
Ultrasound		No research studies used	**Optional activation adjunct**
Injections			
Steroid Injection		One study used	**Not recommended except epidural**
Sterile Water Injection		One study used	**Optional activation adjunct**
Ultrasound		No research studies used	**Optional activation adjunct**
Pharmacology			
Narcotic Analgesics		No research studies used	**Not recommended**
Psychopharmacologic		No research studies used	**Not recommended**
Analgesics / NSAIDS		Combined Studies	**Up to 3 weeks for pain**
Ultrasound		No research studies used	**Optional activation adjunct**
Miscellaneous			
Neck School		One study used	**Recommended**
Work Alternatives		One study used	**Recommended**
Relaxation Technique		One study used	**Recommended**
Acupuncture		One study used	**Not recommended**
Magnetic Necklace		**One study used**	**Recommended**

As you can see physical medicine therapies were mostly not represented in the study determination.

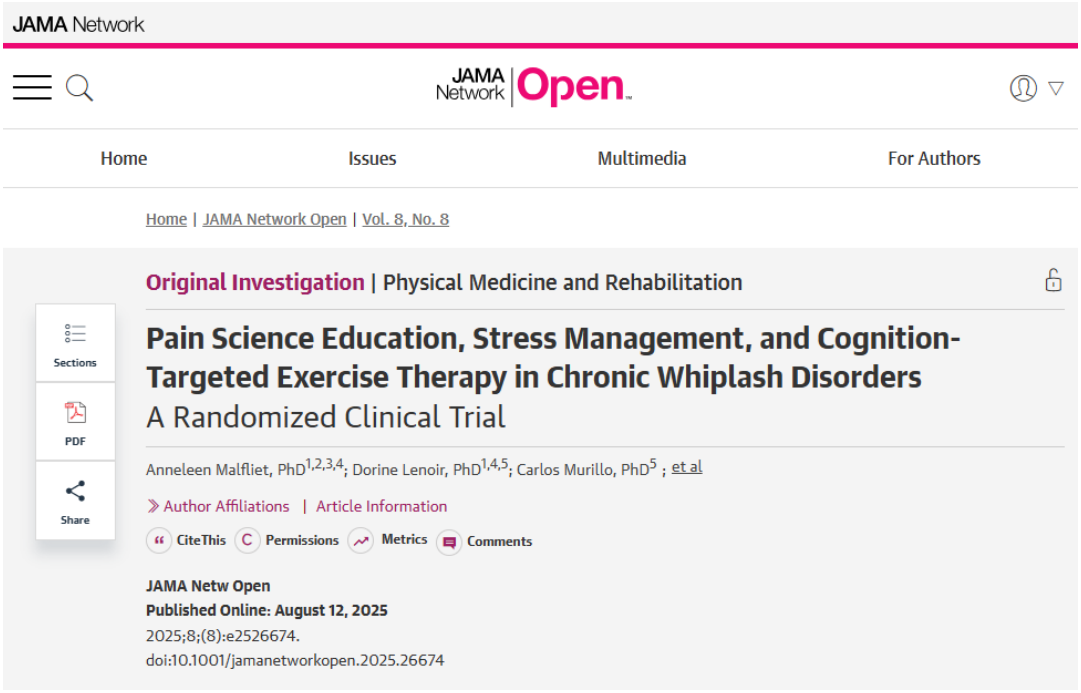
- Based on their research review, the philosophy of the panel involved was that of prudence in the absence of evidence. **They then defined recovery, as those who stopped receiving compensations instead of those whose symptoms have resolved. Thus, the recovery rate stated was 97.1% of individuals in a time frame of one year**.
    - **Doctors performing Insurance Medical Assessments will typically make a generalized statement to the recovery time of soft tissue injuries. This idea of**

recovery is again NOT based off of medical research, experience or review, but rather through a Guideline with the specific intent of cost containment of physical medicine therapies and is why insurers Systemically Discriminate against the Chiropractic profession. Specifically, because most Medical Doctors have no training in Whiplash.

- **You Can see this in the Medical report by Dr [redacted] dated August 7, 2025, in which the doctor states:**

> **3. Does the claimant, as a direct result of the MVA in question, suffer from a predominantly minor injury as defined by the Statutory Accident Benefits Schedule? Please provide your rationale to support your conclusion.**
>
> Yes. Based on detailed history and thorough physical examination, but without the benefit of relevant imaging of [redacted] lumbosacral spine, it is my impression that [redacted] injuries are as follows:
>
> - Mild myofascial strain to the lumbosacral spine (right SI joint local tenderness) with no overt traumatic-based compressive neurological deficit as a direct result of the index accident (within the context of [redacted] age and occupational related degenerative issues).
>
> I do believe that [redacted] stated symptomatology involving the pain in [redacted] right SI joint is related to the motor vehicle accident, within the context of [redacted] age and occupational related degenerative issues. However [redacted] perceived level of pain expressed in the verbal rating scale without an identifiable objective organic source is beyond the expected level of [redacted] injury at this stage of [redacted] rehabilitation, from an orthopaedic perspective. No traumatic-based disabling clinical pathology has been identified as a direct result of the accident at this stage of [redacted] recovery, from a musculoskeletal perspective. [redacted] prognosis, specifically with respect to index accident-related impairments is good, from an orthopaedic perspective.

-
- **First his statement confirms a Chronic Pain process is present, which precludes his opinion being allowed from an Orthopaedic perspective. It must be from a chronic pain perspective. Secondly, he states that an "organic source is beyond the expected level of her injury" which is a statement made by an insurance guideline with the sole intention to reduce physical medicine rehab costs, and thus, the statement is no compliant with his College of Physician and Surgeon's of Ontario Scope of practice that requires him to make his decision based on medical evidence.**



- Whiplash-associated disorders (WAD) include a range of symptoms resulting from indirect neck trauma, often caused by acceleration-deceleration mechanisms.[1] While many individuals recover, ***approximately half will continue to experience ongoing pain and disability 1 year later*** (ie, chronic WAD [cWAD]).[2,3] **Therefore, neck trauma is acknowledged as a significant global health issue, with the economic burden in Europe alone reaching US $22 billion annually**.[4] These costs are largely attributed to ongoing treatment and reduced work productivity.[4]

- ***As functional disabilities in cWAD depend on individual recovery prerequisites and biomechanical preconditions, its management calls for individuality***.[5,6] Additionally, ***research indicates that active interventions are generally most cost-effective***.[7,8] However, managing cWAD remains challenging, as evidence-based guidance is currently limited due to inconsistent outcomes.[9-12] This may be partly due to an inadequate integration of advances in cWAD research, particularly concerning its complex pathophysiology—including altered brain structure and function, ***impaired exercise-induced hypoalgesia***, dysfunctional stress regulation, and psychological factors such as pain-related anxiety[13-17]—which collectively complicate cWAD symptomatology.[13-16]

- ***Please note that the most recent literature on chronic WAD is that of impaired exercise induced hypoalgesia. Meaning performance of exercises without appropriate supervision and instruction, such as performing general ADL's such as Dr. [redacted] suggested will more likely than not trigger a continued pain response, increasing [redacted] overall disability, and prolong both [redacted] recovery and impairment. If Dr. [redacted] disagrees with this, he would have to provide update research, more recent the AMA Journal publication of 9 days ago (August 12, 2025) to be within his scope of practice as per the CPSO guidelines.***

- In addition to this confusing terminology for Recovery, their study only assessed those with the diagnostic code ICD-9 847.0 as the criteria for whiplash injury.
- And Finally, Unsupported conclusions and recommendations.
    - Bias statements were made by the task force such as whiplash injuries are usually
    - benign and that they are almost always self-limiting (section 7 page 10).

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        - The authors also report that patients should be assured of this fact (chapter 8.1 page 3).
        - The task force cited no references to back these conclusions or recommendations.
        - Please see above, as Dr. [redacted] states that **organic source is beyond the expected level of [redacted]injury but never provides supporting research.**
    - The four studies that were accepted by the task force for "favorable" prognosis of WAD actually reported delayed healing and prolonged recovery.
        - Norris and Watt found that 66% of their cohort had neck pain at an average of two years post injury.
        - Radanov et al. found that 27% of their cohort were symptomatic six months post-accident (2 studies)
        - Hildingsson and Toolanen found that 44% of their cohort were symptomatic an average of two years post-accident.
- Review of all long-term Whiplash Peer Reviewed Research Studies shows that on average 70% of those injured in Motor Vehicle Traumas will continue to have pain and disability 15 years post trauma, and over 50% 30 years post trauma.

Specific comments from the QTF Spine Journal Publication

- The Quebec Task Force on Whiplash Associated Disorder reports that the purpose of the development of their whiplash guidelines on page 8S stating, "**The province of Quebec; the Task Force reports an extraordinary expense of some $1.5 million (Canadian Dollars) for physiotherapy, when medical expenses were $230,000. Yet the report clearly finds no proven value for physiotherapy."**
    - This shows that the entire purpose of the QTF and now the MIG, is to shift costs away from physical medicine. This is a Systemic Discriminatory policy for the sole purpose of profit at the policy holders' expense.
- On page 8S, The Quebec Task Force states, "The Quebec Task Force provides a cogent and exhaustive summary of the state of the art as of September 1993."
- On page 8S, The Quebec Task Force emphasizes that whiplash is essentially a benign condition with the vast majority of patients recovering, but it is the refractor minority that accounts for an inordinate proportion of the costs."
- This is where the misguided ideology of soft tissue injuries being self resolving or benign comes from.
- On page 10S, The Quebec Task Force states, "This Task Force addresses the problem of Whiplash and Its associated disorders. Neck pain is to the automobile what low back pain is to the workplace. Whiplash Associated Disorder (WAD) are becoming increasingly worrisome to the Western world. In Quebec along, approximately 5000 whiplash cases annually account for 20% of all traffic injury insurance claims, and the average period for compensation has increased from 72 days in 1987 to 108 days in 1989. In British Columbia and Saskatchewan, two other Canadian Provinces with single-payer motor vehicle insurance programs, claims for whiplash injury represent 68% and 85% of the automobile injury claims, respectively. In addition, whiplash injury presents a substantial financial burden to society."
- On page 11S, the Quebec Task Force states, "After 3 years of deliberations by the Task Force, the evidence was found to be sparse and generally of unacceptable quality. The original research articles in the literature strained our capacity to adhere strictly to best evidence synthesis methodology." They go on to say, "Surprisingly little evidence relevant to epidemiology, clinical decision, preventive interventions and rehabilitation was found."
- On page 12S, the Quebec Task Force states, "Finally, the cost of whiplash injuries sustained in motor vehicle collisions represent a substantial financial burden to the SAAQ." The organization funding this study.
- On page 12S, the Quebec Task Force states, "SAAQ policy dictates that motor vehicle collision subjects who can return to work or to their usually activities within 7 days of the collision are ineligible to received compensation to replace regular income but may receive reimbursement for

expenses. Such subjects, whose injuries were presumably minor, were assigned a mean duration of 3.5 days, or one half of the 7 days. Because the duration of compensation is measured cumulatively by the SAAQ and does not allow successive intervals of compensation to be distinguished in case of recurrence, the study cohort for this first outcome excluded all subjects who experienced recurrence."

- On page 21S, the Quebec Task Force states, "Our understanding of what happens to the cervical spine during low-velocity, rear end collisions is limited, despite a wealth of experimental studies on the biomechanics of the cervical spine. For the purpose of this report, the Task Force recommends the study by McConnell et al for this description of the kinematic response of human test subjects to low velocity, rear ended impacts. This study suggests that a 6 to 8 km/h impact, which subjects the cervical spine to as much as 4.5 G, continues the threshold for mild cervical strain injury. The test subjects experience a rapid compression-tension cycle directed axially through the cervical spine as a result of the torso ramping up the seatback. Extreme hyperextension-hyperflexion of the cervical spine, commonly reported in cadaver and mannequin experiments were not observed. The authorized theorized that mild clinical symptoms experienced after low velocity, rear ended collisions might result from forces directed axially through the cervical spine rather than by the classic hyperextension-hyperflexion mechanisms."

    - Affidavit of Whitman E. McConnell, MD dated April 18, 1997, which reads.
    - "The BRC (Biodynamic Research Corporation) tests were not conducted to statistically establish injury rates or thresholds for large populations of normal or previously injured people. The study design and protocol were not intended to achieve that purpose, nor did the reported results state those conclusions."
    - Superior Court of the State of Arizona, county of Maricopa, Civil Action No. CV 95-21280; Affidavit of Whitman E. McConnell of April 18, 1997.
- On Page 22S: Whiplash is an acceleration – deceleration mechanism of energy transfer to the neck. We propose a classification of WAD on two axis: 1) a clinical-anatomic axis and 2) a time axis. This proposed classification for whiplash injuries, or WAD injuries is the current model used by the Ontario Minor Injury Guideline today.
- On page 22S, the Quebec Task Force states, "Apart from anatomic studies, much of the scientific understanding of soft tissue injury and healing is derived from animal models, and there is little information on the normal recuperation period. In animal model of soft tissue healing, there is a brief period (less than 72 hours) of acute inflammation and reaction, followed by a period of repair and regeneration (approximately 72 hours to up to 6 weeks) and finally by a period of remodeling and maturation that clan last up to 1 year. Starting from this model, it is reasonable to estimate a healing period of between 4 to 6 weeks in cases of WAD with partial tear of the soft tissue."
    - This was based off of research that ended in 1993.
    - In 1997, Yale Medical School discovered the injury mechanism of whiplash, a reverse S Curve that results in neurological injury due to spinal kinematics.
        - Panjabi MM, Cholewicki J, Nibu K, Grauer JN, Babat LB, Dvorak J. Mechanism of whiplash injury. Clin Biomech (Bristol). 1998 Jun;13(4-5):239-249.
            - In 1997, researchers at Yale University School of Medicine conducted pivotal studies that transformed the understanding of whiplash injury mechanisms. Utilizing high-speed cineradiography on human cadaveric cervical spines subjected to simulated rear-end collisions, they observed a distinct bi-phasic kinematic response of the cervical spine. During the initial phase of impact, the cervical spine formed an "S-shaped" curve characterized by flexion in the upper cervical segments and simultaneous hyperextension in the lower segments, particularly at the C6-C7 and C7-T1 levels. This non-physiological curvature occurred within milliseconds of impact and was associated with injurious tissue distortions, especially in the lower cervical spine. **The study concluded that such rapid deformation could lead to neurological injuries due to the abnormal spinal kinematics induced during rear-end collisions**.

        - **These findings would NOT present during typical ENT or Neurological examinations as they are associated with soft, not hard neurological impairments.**
    - These findings were further substantiated by subsequent studies on live human volunteers, which confirmed the occurrence of the S-shaped curvature during whiplash events. The research provided a biomechanical basis for understanding the pathophysiology of whiplash-associated disorders and highlighted the potential for neurological injury resulting from the rapid and abnormal movement patterns of the cervical spine during such incidents.
    - Panjabi MM, Ito S, Pearson AM, Ivancic PC. Injury mechanisms of the cervical intervertebral disc during simulated whiplash. Spine (Phila Pa 1976). 2004 Jun 1;29(11):1217-25.
    - Panjabi MM, Cholewicki J, Nibu K, Grauer JN, Babat LB, Dvorak J, Bär HF. Biomechanik des Beschleunigungstraumas [Biomechanics of whiplash injury]. Orthopade. 1998 Dec;27(12):813-9.
- On page 24S, the Quebec Task Force states, “The inclusion criteria for the pool of potentially relevant articles from the sources described above were: 1. An article or report published from 1980 to September 1993 and appearing in Medline or found by other means.”
- On page 34S, The Quebec Task Force states, “Patients should be reassured that WADs are almost always self-limited. Health professionals caring for patients with WAD should emphasize that most incidents of WAD are self-limited, involving temporary discomfort and rarely resulting in permanent harm. The key message to WAD patients is that pain is not harmful, is usually short-lived, and is controllable”
    - **Any doctor that recites these statements in any medical report is uneducated regarding whiplash traumatology research and instead is reciting medicolegal recommendations rather than objective medical evidence. As such they should be considered a “hired gun” and biased.**
    - **While an orthopedic surgeon’s (IME report) input is valuable in evaluating surgical conditions, it must be acknowledged that the mechanism-of-injury analysis lies outside the routine scope of orthopedic surgical training. It is not standard practice for orthopedic specialists to perform crash reconstruction, analyze delta-V or occupant motion, or assess subtle neuromusculoskeletal sequelae not requiring surgical correction. Therefore, any opinion suggesting the injury “organic source is beyond the expected level of [redacted] injury” should be viewed with caution, particularly if it lacks:**
        - **Specific reference to crash dynamics.**
        - **Biomechanical modeling.**
        - **Consideration of known soft tissue injury thresholds.**
        - **Pain evaluation and testing.**
    -
- On page 37S: Professional Education Related to Whiplash Associated Disorders: Findings: “Training of practitioners and health science students in the management of WAD is deficient. Educational opportunities for clinicians in all health science faculties, including medical students, provides insufficient preparation for the management of WAD.”
- On page 38S-39S: “Unfortunately, there are significant gaps in the teaching of these skills and knowledge in the training programs of all clinicians. Some specialists in various disciplines (medicine, physiotherapy, occupational therapy, biomechanics, and chiropractic) have acquired these fundamental skills through individual voluntary postgraduate training. Most formal specialty training, however, does not encompass all the necessary areas of knowledge and skills for the management of musculoskeletal disorders. **We must realize that most primary interventionists in the management of WAD have little chance of being effective given the present university teaching curricula. There should be a considerable effort made to educate clinicians already involved in the management of WAD through postgraduate education programs**.”

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Statement of Unique Educational Program Accreditation in Whiplash Traumatology.

As cited in the Quebec Task Force on Whiplash-Associated Disorders (WAD), pages 38S–39S:
"Unfortunately, there are significant gaps in the teaching of these skills and knowledge in the training programs of all clinicians. Some specialists in various disciplines (medicine, physiotherapy, occupational therapy, biomechanics, and chiropractic) have acquired these fundamental skills through individual voluntary postgraduate training. Most formal specialty training, however, does not encompass all the necessary areas of knowledge and skills for the management of musculoskeletal disorders. We must realize that most primary interventionists in the management of WAD have little chance of being effective given the present university teaching curricula. There should be a considerable effort made to educate clinicians already involved in the management of WAD through postgraduate education programs."
In direct response to this acknowledged educational gap, I developed the only two postgraduate continuing education programs in whiplash traumatology that have received dual accreditation and formal recognition from both the medical and chiropractic communities—qualifying for Continuing Medical Education (CME) and Continuing Chiropractic Education (CCE) credits.

- The first program was launched in 2008, and the second in 2021.
- Both curricula were rigorously designed to integrate the most current research in spinal kinematics, injury biomechanics, neurophysiology, and evidence-based clinical protocols.
- These programs uniquely bridge the interdisciplinary gap between chiropractic and medical professionals, offering a standardized, scientifically grounded framework for the diagnosis, assessment, and management of Traumatic Cervical Syndrome (formerly known as Whiplash or WAD injuries).

The dual-accreditation status of these programs underscores their scientific validity, educational rigor, and clinical relevance—establishing a benchmark that remains unmatched in the field of whiplash traumatology education.

In light of the Quebec Task Force's conclusions, these programs represent the Gold Standard in postgraduate education and provide a medical guideline-level framework for practitioners managing traumatic cervical spine injuries.

Statement on Expert Authority in Whiplash Traumatology

Given the well-documented educational gaps in the formal training of healthcare providers in the management of Whiplash-Associated Disorders (WAD)—as explicitly noted by the Quebec Task Force on WAD (pages 38S–39S)—it must be clearly stated that I am the author and developer of the only two postgraduate educational programs in Whiplash Traumatology to have received dual accreditation from both the medical and chiropractic communities, qualifying for CME and CCE credits.

These programs, launched in 2008 and 2021, were created in direct response to the Quebec Task Force's call for advanced, interdisciplinary postgraduate training and are currently recognized as the Gold Standard in the assessment, diagnosis, and treatment of Traumatic Cervical Syndrome (formerly known as WAD). They serve as de facto medical guidelines in this area of clinical care.

Therefore, to solicit or rely on the opinion of a healthcare provider who has not received equivalent postgraduate education or formal recognition in Whiplash Traumatology—in an effort to dispute the necessity, appropriateness, or effectiveness of care I have recommended—would not only reflect a lack of expertise but would constitute a deceptive and misleading tactic. It undermines established, peer-reviewed, and accredited clinical frameworks and disregards the authority of the very guidelines that I authored and that have been recognized across multiple healthcare disciplines.

In any matter involving the diagnosis and treatment of WAD-related injuries, my expertise represents the highest available standard, both academically and clinically.

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2008-2010 Whiplash Traumatology and Treatment Seminar Series

- Continuing Medical and Chiropractic Education Accreditation Credit (105 hours) Provided by:
  - University of Buffalo School of Medicine and Biomedical Sciences
  - National University of Health Sciences
  - American Chiropractic Association
  - American Academy of Family Physicians
  - 

2021 (Seminar March 2021 to 2024) – Currently Accredited and Endorsed

- Continuing Medical Education Credit (32 Hours) Provided by:
  - Michigan State University Medical and Osteopathic School.
  - European Chiropractor's Union
  - NorthEast College of Chiropractic
  - National University of Health Sciences
  - Academic Endorsement McMasters University Medical School
  - This program has medical, chiropractic, physical therapy and massage therapy accreditation and endorsement in 29 countries.
  - 

  - 

2024 - Present – Currently Accredited and Endorsed

- Continuing Education Credit (32 Hours) Provided by:
  - European Chiropractor's Union
  - National University of Health Sciences
  - 

In summary the Task Force came into existence with the sole purpose of developing treatment guidelines that would reduce overall insurer claim costs, which at the time were seen as costs driven by physical medicine therapies such as Chiropractic. Physical medicine therapies were nearly 6.5 time more costly than pharmaceutical intervention ($1,500,000.00 vs $230,000.00). The findings of the QTF, after 3 years of deliberations found that the evidence regarding whiplash injury and treatment need was sparse and generally, of unacceptable quality, however, they still develop treatment guidelines which stated, "it is reasonable to estimate a healing period of between 4 to 6 weeks in cases of WAD with partial tear of the soft tissue." The key message was that WAD pain is not harmful, is usually short-lived, and is controllable"

These findings are what the insurer is using today, to adjudicate claims. This Systemic Discrimination of Chiropractic based on the ideology of Whiplash being a soft tissue injury, that it is self resolving and that it has a typically healing period of 4-6 weeks is unreasonable and based off of research that is over 37 years old. This ideology is no longer pertinent to the claims handling process of today and has no place in the Ontario Insurance system.

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Chiropractic Doctors are spinal injury specialists, obtaining nearly 5000 clinical and academic hours of training specifically on the structure and function of the spine. Whiplash injury is a form of Traumatic Cervical Injury that results in a number of clinical syndromes. This Traumatic Cervical Syndrome is defined as the "biological and neurological consequences for the cervical spine and nervous system caused by neck trauma, and is a syndrome comprising various symptoms of the motor and nervous system but also mental, neurological, as well as ontological, and visual balance dysfunction"

- Rosenfeld M: Whiplash. The American Journal of Medicine. Vol 110, Issue 8, P: 667-668, June 1, 2001.

As Chiropractic Doctors are the primary doctors that know this material and the primary doctors performing day to day treatment on whiplash patients that have sustained Traumatic Cervical Syndrome, the insurer has designed specific policies and procedures to limit recommendations by Chiropractic Doctors, with the sole intention of claim cost reduction, which is Systemic Discrimination.

Enabling Recovery from common Traffic injuries: A focus on the Injured Person NAD

Minor Injury Treatment Protocol: The Final Report of the Minor Injury Treatment Protocol Project, titled "Enabling Recovery from Common Traffic Injuries: A Focus on the Injured Person" (Final Report) was delivered to FSCO at the end of December 2014. The Final Report recommends treatment based on extensive research by world renowned medical and scientific experts. The research complies with rigorous scientific methodologies and research protocols.

- ***http://www.fsco.gov.on.ca/en/auto/Pages/minor-injury-treatment-protocol.aspx***
- ***This was funded by the Financial Service Commission of Ontario***
- ***On page 39, the primary authors were authors from the QTF, and the primary expert panel was from Aviva Canada.***
- ***On page 42, the lead authors funding including the insurance work safety board and Aviva Canada.***
- ***The authors reported on page 6, "Having considered the narratives of persons who experienced injuries and received care under the MIG, we have concluded that it is NOT appropriate to categorize either the injuries or their associated symptoms as minor injuries, and as much as they can be associated with a broad range of symptomology, and with some degree of disability for activities of daily life or work. It is our view that there is no scientific rationale or merit in continuing to employ the term minor injury."***
- The authors reported that this new guideline was for what they called type 1 injuries.
- The authors idea of WAD or NAD 1 was that it is time limited and will resolve by itself.
- The authors idea of Type 2 injuries, which would be all whiplash injuries as the authors state,
- "Would involve a substantial loss of anatomic alignment or structural integrity", which is the Reverse S Curve, "will require a significant amount of therapy to ensure optimal recovery."
- On page 67, the scope of their assessment was to review those injured over 18 years old, who spoke English, within 3 months of their MVA.
- ***On page 82: The NAD Guideline specifically states that it DOES NOT cover pain that "persists for more than 6 months."***
    - ***Reported to be present in the Orthopedic IME report.***
- ***On page 120, "The guideline does not cover headaches that persist more than six months post collision."***
    - ***Reported to be present in the ENT IME report.***

What we have learned since the publication of the QTF, 37 years ago.

Whiplash results in a Hyper-translation force occurring in the cervical spine which forces the cervical segments beyond their physiologic limits in a few milliseconds, causing tissue failure during the initial phase of the energy transfer and resulting in shearing and compression forces on the discs and

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zygapophyseal joints. As noted by the QTF, an axial direction force does start the Whiplash Injury mechanism. However, at the time of the QTF publication, the consequence of this upward Axial Force was unknown. In 1997, Dr. Panjabi at Yale Medical School Biomedical Sciences discovered that the injury mechanism in whiplash is the development of a “Reverse S Curve”. Dr. Panjabi stated, “A vertical force continues upward into the neck it initiates flexion of the upper cervical segments and hyperextension of the lower segments. This is the development of a reverse S curve. This formation continues as the torso continues to move forward this primary shear force effect will translate through the C5-C6 motion segment. This was confirmed the following year at Yale Medical School in a follow-up study and then a third time in Japan.

- Tanaka N, Atesok K, Nakanishi K, et al. Pathology and Treatment of Traumatic Cervical Spine Syndrome: Whiplash Injury. Adv Orthop. 2018;2018:4765050. Published 2018 Feb 28.
- Grauer JN, Panjabi MM, Cholewicki J, Nibu K, Dvorak J. Whiplash produces an S-shaped curvature of the neck with hyperextension at lower levels. Spine (Phila Pa 1976). 1997 Nov 1;22(21):2489-94
- Panjabi MM, Cholewicki J, Nibu K, Babat LB, Dvork J: Simulation of whiplash trauma using whole cervical spine specimens. Spine 23: 17-24, 1998 (Yale Medical School Biomedical Science Lab).
- Koji Kaneoka, Koshiro Ono, Satoshi Inami and Koichiro Hayashi (99-04-15). "Motion analysis of cervical vertebrae during whiplash loading." Spine 24(8): 763-770.

This Traumatic Cervical Syndrome (formerly called WAD/Whiplash) comprises the various symptoms that occur as a result of external force such as that of a traffic accident. Traumatic Cervical Syndrome is defined as the “biological and neurological consequences for the cervical spine and nervous system caused by neck trauma, and is a syndrome comprising various symptoms of the motor and nervous system but also mental, neurological, as well as ontological, and visual balance dysfunction”

Researchers have found that ultimately, the spinal cord may become draped and tensioned over the posterior aspects of the vertebral body due to the Reverse S Curve that results from Whiplash, thereby compromising vascular supply. Even more concerning is that in this setting, myelopathic symptoms may develop in patients, which can lead to stepwise and potentially irreversible neurologic injury and continued chronic pain.

- Cho S, Safir S, Lombardi J, Kim J: Cervical Spine Deformity: Indications, considerations, and Surgical Outcomes. American Academy of Orthopaedic Surgeons. June 15, 2019, Vol 27, No. 12.

This understanding and idea of Whiplash Traumatology being a Traumatic Cervical Syndrome is VERY IMPORTANT! It is important, because it shows that only Chiropractic Doctors Scope will allow for a full and detailed examination of patient need, whereas a Medical Doctors scope will be intentionally compartmentalized, allowing for a more attenuated examination, with the basic understanding by the auto insurer that the totality of the individuals’ injuries will not fully be assessed during the determination of need.

- **We specifically see this in the Orthopaedic Surgeon report where the doctor diagnosis and accident related Sacroiliac chronic pian conditions, recommends and MRI, and then denies both a Chronic Pain assessment and Physical Medicine Treatment, against what the most up to date current peer reviewed literature suggests.**

This is specifically why the insurers developed policy and procedure to Systemically Discriminate against Chiropractic with the understanding that a full person assessment would then not be completed when determining insured need, allowing for displacement of medical rehabilitation costs from the insurer to the publicly funded OHIP system.

This is a deliberate and designed deceptive tactic, with specific intent to systemically discriminate for financial gain which then violates my Canadian Charter of Rights to gainful employment as this discrimination pushes care onto a publicly funded program that does not include Chiropractic care. Understanding Allopathic Medicine (Medical Doctors) vs. Alternative Medicine (Chiropractors) and

how this difference in scope allows for reduced insurer Medical Rehabilitation costs at the expense of the insured and all Ontarians paying taxes.

In Allopathic (Conventional) Medicine, there is a specialist for every part of your body. Neurologists for the brain, Gastroenterologists for the digestive system, Cardiologists for the heart and so on. This compartmentalization of body systems results in a more disjointed approach to addressing disease, with one doctor focusing on solely one body system and not addressing the patient in a holistic manner. Whereas Alternative / Chiropractic treatment provides individualized, personalized medical care that focuses on discovering the underlying factors that cause symptoms. The insurer knows this and has developed a specific set of policies and procedures to limit Chiropractic opinion based on this concept to intentionally drive down claim costs. This is Systemic Discrimination.

The insurer depends on these policies and procedures to Systematically Discriminate against Chiropractors based on a calculated risk that the Medical Doctors review will limit the scope of the assessment to a body part or sub-system, such as the "musculoskeletal system", or a perspective such as "from an orthopedic perspective or neurological perspective" in order to reduce claim exposure.

- **Dr [redacted] report.**

  Nonrelevant pre-existing conditions noted from a otolaryngology perspective that would serve as a barrier to maximal recovery.

-
- **Dr [redacted] report.**

  3. Does the claimant, as a direct result of the MVA in question, suffer from a predominantly minor injury as defined by the Statutory Accident Benefits Schedule? Please provide your rationale to support your conclusion.

  Yes. Based on detailed history and thorough physical examination, but without the benefit of relevant imaging of [redacted] lumbosacral spine, it is my impression that [redacted] injuries are as follows:

  Mild myofascial strain to the lumbosacral spine (right SI joint local tenderness) with no overt traumatic-based compressive neurological deficit as a direct result of the index accident (within the context of her age and occupational related degenerative issues).

  I do believe that [redacted] stated symptomatology involving the pain in [redacted] right SI joint is related to the motor vehicle accident, within the context of [redacted]age and occupational related degenerative issues. However, [redacted] perceived level of pain expressed in the verbal rating scale without an identifiable objective organic source is beyond the expected level of [redacted] injury at this stage of [redacted] rehabilitation, from an orthopaedic perspective. No traumatic-based disabling clinical pathology has been identified as a direct result of the accident at this stage of her recovery, from a musculoskeletal perspective. [redacted] prognosis, specifically with respect to index accident-related impairments is good, from an orthopaedic perspective.

-
- **Dr [redacted] report.**

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. **Did the claimant sustain an impairment as a direct result of the motor vehicle accident? If yes, describe.**

From a neurologic perspective, there were no current accident-related objective neurologic impairments.

Insurers know that Chiropractors are functional spine specialists that look at the entire function of the body and associated injury when determining treatment need. While this is warranted and necessary in order to determine a whiplash injury, insurers specifically discriminate against Chiropractors opinion in lieu of a medical opinion in order to only provide acute injury treatment, as OHIP does even though this would then violate their good faith contractual agreement with the insured, as the insureds auto policy does not list "acute" rehabilitation only. This is a deceptive bad faith act that is in place, and which requires the discrimination of an entire profession to achieve.

CanLII Chiropractic Act, 1991. S.O. 1991 Chapter 21.

"Scope of practice: 3 The practice of chiropractic is the assessment of conditions related to the spine, nervous system and joints and the diagnosis, prevention and treatment"
SO 1991, c 21 | Chiropractic Act, 1991 | CanLII

Traumatic Cervical Syndrome is defined as the "biological and neurological consequences for the cervical spine and nervous system caused by neck trauma, and is a syndrome comprising various symptoms of the motor and nervous system but also mental, neurological, as well as ontological, and visual balance dysfunction"

By definition, Chiropractors are the primary medical specialty with a scope of practice that includes assessment of the Spine, nervous system and musculoskeletal system, all three systems associated with Traumatic Cervical Syndrome and thus would be the leading experts specifically trained to assess and treat whiplash injuries.

This is one reason why I am the ONLY doctor in the world that is accredited to teach Whiplash Traumatology assessment, diagnosis and treatment to ALL health professions treating whiplash. Because whiplash is a spinal biomechanical injury that results in spinal instability and neurological dsyfunction.

The insurers have shown intentional bad faith that has led to a lack of equal consideration regarding benefit need which was discussed in both Shea v. Manitoba Public Insurance Corp and Usanovic v. Penncorp Life Insurance Co.

In Shea, the British Columbia Supreme Court explained that where a third-party action may result in a judgment over policy limits, the insurer defending the action is required "to give at least as much consideration to the insured's interests as it does to its own interests". In this specific complaint the insurer has failed to give equal consideration of need, as they have specifically choose a medical doctor in a different filed of medicine with a different scope of practice to evaluate a Chiropractic treatment plan, based on a calculated risk that the medical evaluation would narrow the scope of assessment based on their own scope of practice, and in turn limit/reduce the overall benefit recommendations to the insured, even though the entire OCF 18 request was not fully considered.

In Usanovic v. Penncorp Life Insurance Co. The Court stated that the insurance owed a duty of good faith in contract that includes the duty "to act both promptly and fairly when investigating, assessing and attempting to resolve claims made by its insureds". By failing to consider my OCF 18 request and failing to have the request evaluated by a doctor in the same profession, in my opinion the claims adjuster failed to meet the standard set by Usanovic v. Penncorp Life Insurance Co.

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- Shea v. Manitoba Public Insurance Corp., [1991] B.C.J. No. 711
- Usanovic v. Penncorp Life Insurance Company (La Capitale Financial Security Insurance Company), 2017 ONCA 395

Appendix B: Canadian Medicare / OHIP System

In Canada, our OHIP system differentiates Allopathic Physicians from Alternative Medicine doctors in that Allopathic Physicians that work in a first party payer system (OHIP) provide services that are required to be provided in an acute-care hospital setting only. These are acute life saving diagnosis and treatment therapies such as performing MRI, CT, and PET Scans, performing surgery or administrating pharmaceuticals.

Chiropractors on the other hand are doctors that preform non-acute/life threatening comprehensive rehabilitation care and services in a clinical based setting. Our OHIP system shows the variation in scope, in which medical doctors are tasked with saving lives and Chiropractic Doctors are tasked with returning those injured lives to as close to pre-injury status as possible.

Basic Understanding of OHIP

"There is a widespread impression among Canadians that their health-care system is universal, comprehensive, and equitable. [1] Little is known about the economic burden of chronic pain and how chronic pain affects health care utilization. In a research study conducted in the Journal of Pain in 2016, authors attempted to estimate the annual per-person incremental medical cost and health care utilization for chronic pain in the Ontario."

The authors performed a retrospective cohort study using Ontario health care databases and the electronically linked Canadian Community Health Survey (CCHS) from 2000 to 2011. The authors found that the incremental cost to manage chronic pain was $1742.00 per person, 51% more than the control group. The per-person cost to manage chronic pain is substantial and more than 50% higher than a comparable patient without chronic pain. Costs are higher in people with more severe pain and activity limitations.

1. Emery JCH, Kneebone R: The School of Public Policy SPP Research Paper. Universtiy of Calgary. Vol 6, Issue 32, October 2013.
2. Hogan ME, Taddio A, Katz J, Shah V, Krahn M. Incremental health care costs for chronic pain in Ontario, Canada: a population-based matched cohort study of adolescents and adults using administrative data. Pain. 2016 Aug;157(8):1626-33

"The Canada Health Act (CHA) uses the term "medically necessary" to define medical procedures and treatments to be paid for by the publicly funded Medicare system. In Canada's health-care system, the term has come to refer almost exclusively to those services provided by a physician, or provided within a hospital setting, by a physician or other staff. Services that a reasonable person might consider "necessary," but are provided outside those settings, are typically not covered. [1] Most Canadians, for example, would be surprised to find that the public system does not pay the full and potentially catastrophic costs of rehabilitation services following a stroke or brain injury, but it does fully cover low-cost and regularly incurred services, such as annual physicals and receiving advice on dealing with cold symptoms. Is this a rational or desirable use of a public-insurance system? [1] Cathy Charles and co-authors suggest that medical necessity has been understood to mean "what doctors and hospitals do." [1]

If we start from the premise that provincial governments wish to continue keeping their financial commitment to health care limited to paying the costs of hospitals and doctors as required under the Canada Health Act, then the objective for the public payer is not to reform the system to an "ideal" health-care system, meeting all medical needs. Rather, it is to ensure that all acute-care-treatment needs associated with service delivery in a hospital and/or by a physician are met. The objective for the public payer would be to use a definition of "medical necessity" to control health expenditures, by eliminating the

obligation to fund medically unnecessary physician services, services that do not need to be provided in an acute-care hospital setting, and to manage the adoption of new services arising through technical change. **If a medically necessary service could be provided by a service provider other than a physician, and outside of a hospital setting, then more medically necessary care could be moved out of the medicare basket into the mixed-finance payment-service categories, with important consequences for the public payer's commitments, for the demand for service providers in the system, and for patients accessing care.**

- The insurers Systemic Discrimination of Chiropractic does the exact opposite.

A background paper prepared for the Commission on the Future of Health Care in Canada — popularly known as the Romanow Commission — describes medical necessity as the criterion for determining the division of services between the first-dollar, single-payer public coverage under Medicare and the mixed-payment arrangement: "When a service provided to a patient is medically necessary, it is fully funded by the government and delivered based on the patient's need, not their ability to pay. If a service is deemed unnecessary, however, patients must pay for it directly. The idea is to have need, not want, dictate what the healthcare system provides." In contrast to the Romanow Commission's view, Canadian courts have ruled that Medicare is not based on broadly defined healthcare needs but instead it is based on a "sectoral" consideration of medical necessity. **In ruling on the Auton case, the Supreme Court of Canada, in a unanimous decision, remarked that Canadian Medicare "is, by its very terms, a partial health plan and its purpose is not to meet all medical needs."**

1. *Auton (Guardian ad litem of) v. British Columbia (Attorney General), 2004 SCC 78 (CanLII), [2004] 3 SCR 657, http://canlii.ca/t/1j5fs.*
2. *As OHIP is not intended to provide rehabilitaiton services, it is my opinion that when an insurer unjustly denies warranted benefits for rehabilitation by intentionally limiting the scope of Independent Medical Assessments by Systemically Discriminating against Chiropractic, resulting in limiting the $50,000.00 cap to $3,500.00. The insuer is then causing intentional harm on the insured that they have a contractual obligation with. Both mental and physical harm which can be proven based on pain pathophysiology research and the HPA Axis.*
3. ***This deceptive act of intentionally limiting the scope of Independent Medical Assessments by Systemically Discriminating against Chiropractic can be seen when therapy needs are based on a "neurological, ENT or orthopedic perspective" instead of a whole person perspective, which also never considers the insures chronic pain, which was diagnosed by the Orthopaedic Surgeon in his IME report.***

OHIP Delisting Healthcare Services

The federally legislated definitions of medical necessity leave discretion for how provinces define what hospital and physician services are medically necessary or medically required, and what levels of services are medically necessary. Provinces can "delist" those services provided by physicians that government determines are not "medically necessary" or are not necessary to provide in a hospital setting. Provinces can also define a level or frequency of service as medically necessary and define additional services, or higher service levels, as enhanced services that can be paid for by private sources.

It is not the case that other categories of service are not medically necessary, only that the public payers have defined the limits of their hard commitment for first-dollar, universal, single-payer coverage to doctors and hospitals. Delisting does not necessarily eliminate the availability of the "medically unnecessary" service; it instead moves the service into the mixed-payment category of services."

1. *Auton (Guardian ad litem of) v. British Columbia (Attorney General), 2004 SCC 78 (CanLII), [2004] 3 SCR 657, http://canlii.ca/t/1j5fs.*

The insurer has shown intentional bad faith by using a medical doctor (in a first-dollar system) to evaluate a Chiropractic Doctors service recommendation (in a mixed-payment system) that has led to a lack of

equal consideration regarding benefit need which was discussed in both Shea v. Manitoba Public Insurance Corp and Usanovic v. Penncorp Life Insurance Co. as previously stated.

I believe that Ontario (Health) v. Association of Ontario Midwives, 2022 ONCA 458 case can be used as a supporting ruling for an argument of systemic discrimination in compensation or recognition between chiropractors and medical doctors.

Parallels Between Midwives and Chiropractors

Factor	Midwives (as in the case)	Chiropractors (potential application)
Gendered profession	Majority female (traditionally undervalued work)	Majority male historically, but the profession often sits **outside traditional biomedical authority**, facing institutional bias and generally being undervalued.
Non-physician role	Autonomous health professionals, but not MDs	Same: regulated, autonomous, but often undervalued relative to MDs.
Undervaluation	MOH ignored pay equity recommendations	Chiropractors delisted from OHIP; not compensated equally despite managing complex musculoskeletal cases and having more academic training than medical doctors.
Ignored expertise	Government dismissed expert recommendations	Insurers or MDs dismiss chiropractic opinions in medico-legal cases, despite equivalent or superior expertise in certain areas (e.g., whiplash).

General Doctor's Whiplash Scope of Practice: Understanding Whiplash Injury Review:

According to Dr. Arthur Croft, "Whiplash is beyond the training and expertise of most physicians."

- Croft AC: Whiplash and Mild Traumatic Brain Injuries. A Guide for Patients and Practitioners. Spine Research Institute of San Diego Press, Coronado California. 2009

During a Whiplash Injury, Whiplash forces are applied to the spine within a fraction of a second, and this rate of change of tissue length and spinal structure can overwhelm the spine and surrounding tissue's load tolerance, resulting in either permanent deformation or tearing of collagen fibres, disruption of the supportive matrix, and distraction of the spinal cord and spinal nerves. In this circumstance, if cervical spine ligaments and discs are damaged; this reduces stability of the spine post trauma and degenerative changes can start.

These injuries have been experimentally produced in low-speed impacts and can result in a number of clinical findings that include:

- Pressure on nerve roots which can cause:
    - Sensory changes (numbness, tingling, pain).
    - Motor changes (weakness, atrophy).
- Disc Disruption:
    - Discs have mechanoreceptors which provide a biomechanical functional information by sensing excessive pressure or strain in tissue and reflexively shortening it. Forceful bending or loading of the discs may compress the mechanoreceptors in the disc enough to activate a protective inhibition of muscles producing the bending in order to prevent disc or other injury.
- Several studies have shown that disc herniation occurs over time following trauma which is likely a result of progressive fiber breakdown which results from transference of load bearing responsibility form damaged fibers to adjacent undamaged fibers.

As these injuries are not at the level of surgical or medical specialist threshold initially, the injury sustained, based on the profession choose to evaluate the treatment plan will be unintentionally minimized by the medical doctor and warranted benefits will be denied, which is the calculated risk that insurers take by systemically discriminating against chiropractic.

This is why Whiplash Traumatology injuries are no longer called “soft tissue injuries” in the medical community, but rather Traumatic Cervical Injuries as is discussed in this document.

- Please note, this is only a minor portion of the injury mechanism and functional loss that occur in typical whiplash injuries. If further education on this trauma is required, please let me know.

This form of Systemic Discrimination, devaluing Chiropractic Care and implementing a Medical Hierarchy that does not exist in the Regulated Health Professions Act, 1991 (RHPA), allows Insurers to deflect rehabilitation costs onto the publicly funded OHIP system.

Research has shown that approximately 70% of those sustaining whiplash injury continue to have pain and disability 15 years post trauma (Squires). By denying warranted benefits through policies and procedures of Systemic Discrimination, not only does the insurer violate my Canadian Charter of Rights to gainful employment but they also then reallocate the cost of therapy to the public system which all Canadian must they pay for through our taxes. This cost deflection diverts insurance coverage from a system that covers chiropractic care to one that does not, preventing fair opportunities to gainful employment as per the Charter due to Systemic Discrimination.

This reallocation not only overwhelms family doctor practices (with over 100,000 injuries reported per year (Stats Canada), but results in inundation of the entire medical system preventing those who could benefit from medical specialist appointments the ability to access this care. Currently a large percentage of our taxes go towards OHIP, and this will continue to increase with the increase in Chronic Pain in the general population, all the while, insurers are reporting record profits per quarter, most of which is due to this policy and practice of Systemic Discrimination that was initially stated by Allstate Insurance Company (USA) in the 1990’s.

Systemic Discrimination of Chiropractic Hurts us All

- Approximately 130,122 motor vehicle accident injuries requiring treatment in 2019.
- Actual estimated increased cost of Chronic Pain per person: $1742.00 per year.
- Potential increased cost to OHIP (our taxes) based on Systemic Discrimination of Chiropractic: $226,672,524.00 per year.
- As of 2022 there are 14,826,276 people living in Ontario. https://worldpopulationreview.com/canadian-provinces/ontario-population
- It is estimated that 10,300,000 Ontarians pay taxes (2019).
- https://www.statista.com/statistics/478908/number-of-taxfilers-in-canada-byprovince/#:~:text=In%202019%2C%20about%2010.3%20million%20Ontarians%20filed%20an, Canada%20in%202019%2C%20by%20province%20Number%20of%20taxfilers
- This means that on average our taxes according to the statistics will increase by 4.54% per year to cover the extra cost of Insurance Deflected Medical Rehabilitation Benefits onto the OHIP system.
- At the same time, insurers have reported Premium growth led by continued rate increases.
- This is the same deceptive tactic that Allstate used in the 1990’s to increase premium growth. Deflecting warranted rehabilitation costs onto the publicly funded OHIP system allows for lower premium offers, which then increases the percentage of market share the insurer can obtain.
- Systemic Discrimination of Chiropractic hurts us ALL

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Appendix C: **Medical Doctor vs. Chiropractic Doctor Scope of Practice.**

The medical community at large has a general understanding and agreement that Whiplash Traumatology, its injury mechanisms, assessments, diagnosis, and treatments are NOT taught in Medical, Chiropractic, Occupational or Physiotherapy Schools and is outside of the scope of practice of most medical professionals.

The Regulated Health Professions Act, 1991, S.O. 1991, CHAPTER 18,

Under section 33 states, "**Restriction of title "doctor" 33** (1) Except as allowed in the regulations under this Act, no person shall use the title "doctor", a variation or abbreviation or an equivalent in another language in the course of providing or offering to provide, in Ontario, health care to individuals. 1991, c. 18, s. 33 (1). Under Section 33.2.1, the act lists 5 professions that are allowed to use the title doctor, there is ***NO hierarchy*** of professions or indication of superiority in the act. The 5 medical professions are:

- (a) the College of Chiropractors of Ontario;
- (b) the College of Optometrists of Ontario;
- (c) the College of Physicians and Surgeons of Ontario;
- (d) the College of Psychologists of Ontario; or
- (e) the Royal College of Dental Surgeons of Ontario.

Under section **50** the following table is provide which describes the specific healthcare act associated with each regulated College in Ontario. (See below)

TABLE

Item	Column 1	Column 2
1.	person registered as a chiropodist under the *Chiropody Act*	member of the College of Chiropodists of Ontario
2.	person registered as a dental technician under the *Dental Technicians Act*	member of the College of Dental Technologists of Ontario
3.	person licensed as a denture therapist under the *Denture Therapists Act*	member of the College of Denturists of Ontario
4.	person registered as a chiropractor under the *Drugless Practitioners Act*	member of the College of Chiropractors of Ontario
5.	person registered as a masseur under the *Drugless Practitioners Act*	member of the College of Massage Therapists of Ontario
6.	Repealed. See: Table of Public Statute Provisions Repealed Under Section 10.1 of the *Legislation Act, 2006* – December 31, 2011.	
7.	person registered as a physiotherapist under the *Drugless Practitioners Act*	member of the College of Physiotherapists of Ontario
7.1	person registered under the *Drugless Practitioners Act*	member of the College of Naturopaths of Ontario
8.	person registered as a dental hygienist under Part II of the *Health Disciplines Act*	member of the College of Dental Hygienists of Ontario
9.	person licensed under Part II of the *Health Disciplines Act*	member of the Royal College of Dental Surgeons of Ontario
10.	person licensed under Part III of the *Health Disciplines Act*	member of the College of Physicians and Surgeons of Ontario
11.	person who is the holder of a certificate issued under Part IV of the *Health Disciplines Act*	member of the College of Nurses of Ontario
12.	person licensed under Part V of the *Health Disciplines Act*	member of the College of Optometrists of Ontario
13.	person licensed under Part VI of the *Health Disciplines Act*	member of the Ontario College of Pharmacists
14.	Person registered under the *Ophthalmic Dispensers Act*	member of the College of Opticians of Ontario
15.	person registered under the *Psychologists Registration Act*	member of the College of Psychologists of Ontario
16.	person registered under the *Radiological Technicians Act*	member of the College of Medical Radiation and Imaging Technologists of Ontario
17.	member of the College of Medical Radiation Technologists of Ontario	member of the College of Medical Radiation and Imaging Technologists of Ontario

1991, c. 18, Table; See: Table of Public Statute Provisions Repealed Under Section 10.1 of the *Legislation Act, 2006* – December 31, 2011; 2007, c. 10, Sched. P, s. 20 (2); 2017, c. 25, Sched. 6, s. 17 (1).

As you can see, line 4 shows that members of the College of Chiropractors of Ontario are regulated by the "Drugless Practitioners Act", whereas members of the College of Physicians and Surgeons of Ontario (line 10) are regulated under the "Health Disciplines Act".

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Health Disciplines Act: Separation between professions.

The Health Discipline Committees establish a Health Discipline Committee for each designated health discipline that is specified by an order under section 8 to be governed by a Committee, and (b) designate for each Committee so established a name indicating the designated health discipline for which it is established.

Health Disciplines Act, RSA 2000, c H-2

In Ontario physicians, dentists, chiropractors, optometrists and psychologists are allowed to use the title doctor. According to Berge v. College of Audiologists and Speech-Language Pathologists of Ontario 2016 ONSC 7034, the Divisional Court stated, ""Unlike the five health professions authorized to use the "Doctor" title…..unlike the other professions, audiologist were not entitled to communicate a diagnosis as the cause of an individual's symptoms. In this ruling it states that you have to be a member of one of the groups of health professionals with prima facie entitlement to use the title (see section 33(2) of the RHPA). Second, even if you are a member of one of those professions, ***if you are NOT registered with the relevant regulatory College in Ontario, say the College of Physicians and Surgeons of Ontario, or the College of Chiropractors of Ontario, you cannot use the title "while providing or offering to provide healthcare in Ontario."*** A primary objective for the Colleges seems to be preventing confusion among members of the public. Surprising is that even where a College has no jurisdiction over them, insofar as they are not members of the College, the College can still take legal action impacting the health professional directly, pursuant to the public safety mandate.

- This shows all 5 health disciplines, physicians, dentists, chiropractors, optometrists and psychologists under law are allowed to make a diagnosis and that all 5 health disciplines are individually regulated by their own College to avoid confusion of their unique and different Scopes of Practice by the public.

Medical Doctors are allopathic doctors, where as Chiropractic Doctors are Alternative Doctors.

Allopathic vs Alternative Medicine: Structure vs Function

Allopathic (Conventional) Medicine refers to a system in which medical doctors and other healthcare professionals (such as nurses, pharmacists, and therapists) treat symptoms and diseases using drugs, radiation, or surgery.

Conventional Medicine Refers to the type of treatment, diagnostic analysis and conceptualization of disease or ailment that is the primary focus of the curricula of university faculties of medicine. It is sometimes referred to as traditional medicine or science-based medicine and is the type of medicine that is generally provided in hospitals and in specialty or primary care practice.

In Allopathic (Conventional) Medicine, there is a specialist for every part of your body. Neurologists for the brain, Gastroenterologists for the digestive system, Cardiologists for the heart and so on. There are even specialties inside of a specialty, such as in Neurology where there are over 20 different sub-specialists.

Orthopaedic surgery

- Adult reconstructive orthopaedics
- Foot and ankle orthopaedics
- Musculoskeletal oncology
- Orthopaedic sports medicine
- Orthopaedic surgery of the spine
- Orthopaedic trauma
- Pediatric orthopaedics
- https://www.sgu.edu/blog/medical/ultimate-list-of-medical-specialties/#surgery

In Neurology, there are over 20 different sub-specialists. And these neurological sub-specialties do NOT cover Pain or Functional Neurology, which is a Chiropractic form of Neurology. Functional neurology is based on neuroplasticity theories. It is now known that the brain and nervous system are able to change, and can be malleable, as a response to certain stimuli. The brain can be shaped by cognitive, sensory, motor, or emotional experiences.

This compartmentalization of body systems results in a more disjointed approach to addressing disease, with one doctor focusing on solely one body system and not addressing the patient in a holistic manner. It also allows insurers to deny claims without considering the totality of a person's injury.

- *https://www.cc-seas.columbia.edu/preprofessional/health/types/allopathic.php*

Complementary/Alternative Medicine (CAM): Refers to a group of diverse medical practices and products that are not generally considered part of conventional medicine. Alternative / Chiropractic treatment provides individualized, personalized medical care that focuses on discovering the underlying factors that cause symptoms.

As a Chiropractor, we understand that you must treat the body as an integrated whole in order to treat the specific disease or imbalance — we look to understand the root cause of disease and then treat the cause in order to remove the symptoms, not just alleviate them and by doing this we consider the totality of a person's injury.

In addition, under the "Drugless Practitioners Act", Chiropractors are not permitted to perform Surgery or prescribe Medications which is the exact scope of practice of a Medical Doctor which shows each profession is separate and distinct.

Calculated Risk Based on Current Medical System to Increase Profit through Systemic Discrimination

The insurer is fully aware that, in Ontario, medical doctors operate within the publicly funded OHIP/Medicare system (see Canadian Medicare/OHIP system section). Under the Canada Health Act (CHA), the term "medically necessary" is used to define the scope of procedures and treatments eligible for public funding. In practice, this term has come to refer almost exclusively to services delivered by physicians or within hospital settings, regardless of whether equivalent or superior care is available in other regulated health professions.

As a result, services that a reasonable person may consider medically necessary—such as those offered by chiropractors in the treatment of whiplash and chronic pain—are excluded from coverage solely based on the setting or provider, not on clinical effectiveness or relevance. This structural framework enables insurers to systematically devalue non-physician care.

Statistically, this practice is significant. By reinforcing and adhering to this narrow interpretation of "medically necessary," insurers can reduce the financial liability of whiplash-related claims by an estimated 69% annually, not through better outcomes or care efficiency, but through a sustained and targeted policy of systemic professional discrimination.

Canadian Statistics that show that the majority of traffic injuries are considered "injuries" and not "serious injuries" as noted below.

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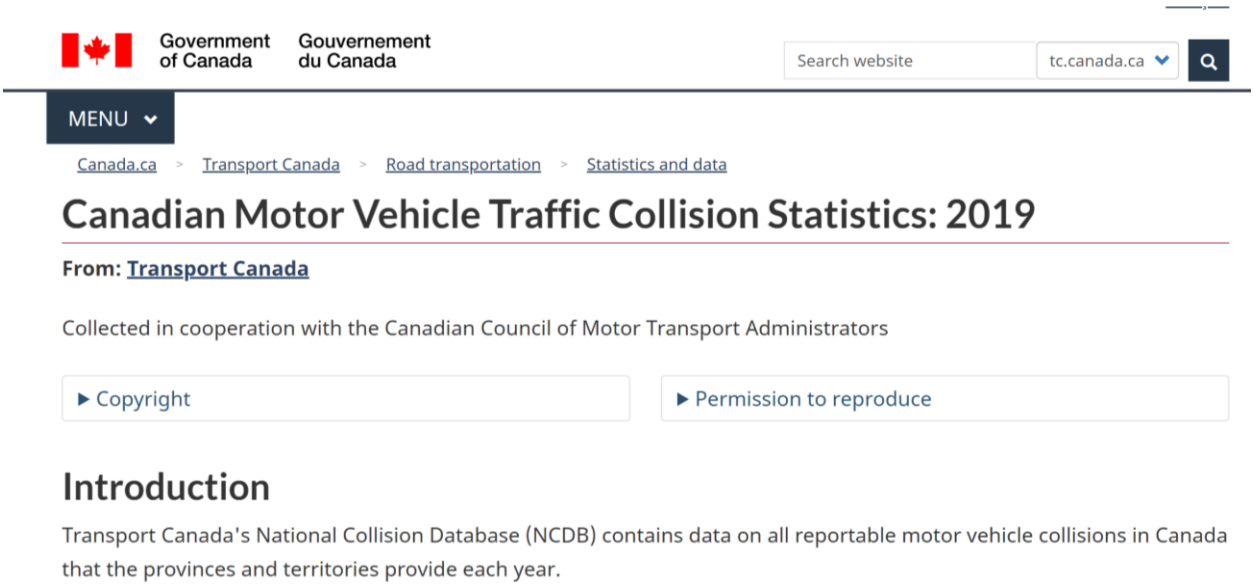
Government of Canada Gouvernement du Canada

Search website tc.canada.ca

MENU

Canada.ca > Transport Canada > Road transportation > Statistics and data

Canadian Motor Vehicle Traffic Collision Statistics: 2019

From: Transport Canada

Collected in cooperation with the Canadian Council of Motor Transport Administrators

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Introduction

Transport Canada's National Collision Database (NCDB) contains data on all reportable motor vehicle collisions in Canada that the provinces and territories provide each year.

Collisions and Casualties - 2000 to 2019

	Collisions		Victims		
Year	Fatal [1]	Personal Injury [2]	Fatalities [3]	Serious Injuries [4]	Injuries [5] (Total)
2000	2,548	153,290	2,904	15,581	222,848
2017	1,698	112,714	1,861	10,104	152,773
2018	1,754	109,580	1,939	9,463	149,065
2019	1,623	104,169	1,762	8,917	140,801

This shows that the majority of rehabilitation requirements fall under the category of “injury”, 153,290, which chiropractors would be responsible for providing the majority of care to vs serious injuries at 15,581 in which medical doctors would be responsible for providing the majority of care.

This deceptive act by the insurers, requesting medical doctors to opinion on the majority of claims that they do not treat results in significant claim cost savings through a detailed and specific policy of systemic discrimination that helps to reduce warranted claim costs to an average of over 69% of Canadians injured in motor vehicle collisions.

Example: Potential Insurers Cost Savings by implementing policies and procedures to Systemically Discriminate Against Chiropractic Doctors

104,169 claims per year (2019) at $3,500.00 (MIG limit) = $364,591,500.00

104,169 claims per year (2019) at $50,000.00 (Policy limit) = $5,208,450,000.00

Medical Doctors approach to evaluation and assessment of injured accident patients, minimizes cost risk based on acute/ambulatory care model to Ontario Auto Insurers to a tune of nearly 5 billion dollars per year.

This ideology and policy is by definition intentional Bad Faith, in which the insurer prevents fair employment opportunity to an entire profession (Canadian Charter violation) by systemically discriminating against chiropractors (using an MD to determine the need of a DC treatment plan), thereby

shifting the potential of the insured to receive warranted treatment, based on their auto policy contract with the insured, from reasonable rehabilitation treatment to acute/acute ambulatory treatment only, potentially limiting 95% plus (based on insurance MIG retainment rates) of their claims costs under the spurious term, soft tissue injury or minor injury, all the while giving the false appearance of prudent claims handling.

Appendix D: **General Doctor's Whiplash Scope of Practice**

What Professional Associations, Colleges and Universities are Saying about Whiplash Injury

Royal College of Physicians and Surgeons of Ontario

- "Whiplash Traumatology is outside the scope of expertise of its members"
    - Royal College of Physicians and Surgeons of Ontario
    - I spoke with the register at the Royal College of Physicians and Surgeons of Ontario who stated on a phone conversation on November 16, 2021, at 11:26 am that the college does NOT offer a training or accreditation in Whiplash Traumatology to their members. This is not a topic that is taught to its members. (This was recorded, recording available upon request –Ontario 1 party consent law. In addition, all calls are reported to be "recorded" by the CPSO when calling in.

Royal College of Physicians and Surgeons of Ontario Specialty Boards

- "I am not aware of Whiplash specifically being part of the current national standards of any or our Royal College recognized disciplines"

[redacted]@royalcollege.ca> Thu, Apr 28, 2022 at 6:10 PM
To: "info@torontopaindoctor.com" <info@torontopaindoctor.com>
Cc: Royal College Canada [redacted]@royalcollege.ca>

Good afternoon, Dr. Mazzarella,

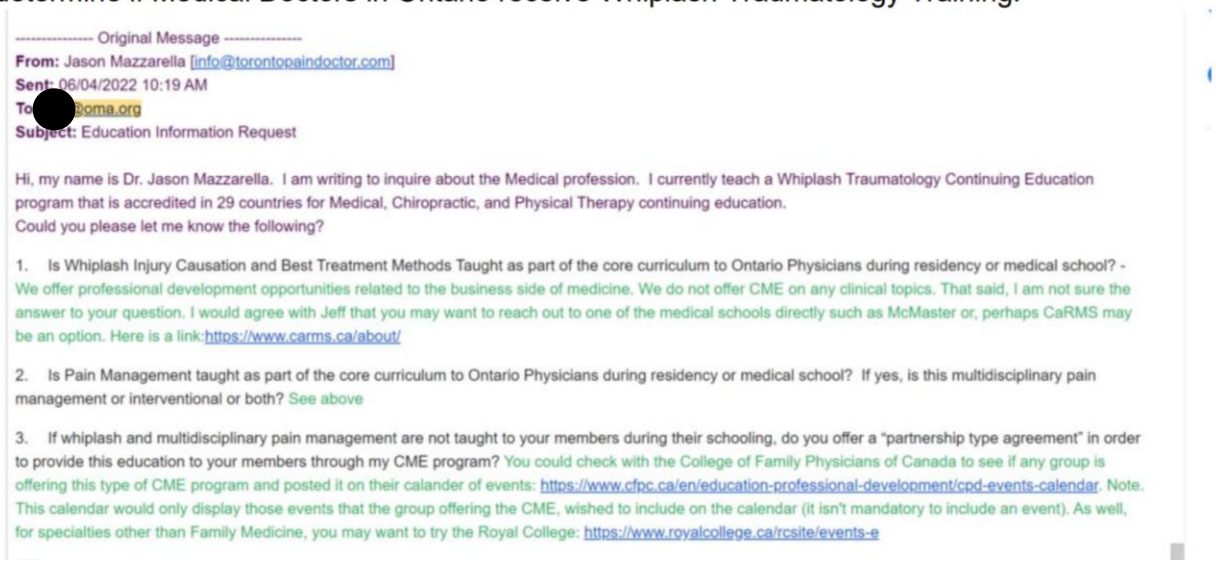
My apologies for the delay in responding to your recent inquiry directed through our Royal College International office. Your inquiry has been forwarded to me since it somewhat relates to the scope of practice of practicing physicians. Let me do my best to respond to your questions.

As a Royal College, whose purview is on specialty postgraduate medical education, [redacted] Our curriculum are national and based on individual specialty disciplines. I am not aware of whiplash specifically being part of the current national standards for any of our Royal College recognized disciplines, [redacted]

Ontario Medical Association (Email correspondence dated April 11, 2022, at 6:30 PM)

- **Question I asked**: Is Whiplash Injury Causation and Best Treatment Methods Taught as part of the core curriculum to Ontario Physicians during residency or medical school?
- **Answer** from Stephaine Huges, Sr. Coordinator, Practice Management & Education, Member Services. "We offer professional development opportunities related to the business side of medicine. We do not offer CME on any clinical topics. That said, I am not sure the answer to your question. I would agree with Jeff that you may want to reach out to one of the medical schools directly such as McMaster or, perhaps CaRMS may be an option."

Stephaine Huges suggests that individual Medical Schools would be the best course of action to determine if Medical Doctors in Ontario receive Whiplash Traumatology Training.



---------- Original Message ----------
From: Jason Mazzarella [info@torontopaindoctor.com]
Sent: 06/04/2022 10:19 AM
To: [redacted]@oma.org
Subject: Education Information Request

Hi, my name is Dr. Jason Mazzarella. I am writing to inquire about the Medical profession. I currently teach a Whiplash Traumatology Continuing Education program that is accredited in 29 countries for Medical, Chiropractic, and Physical Therapy continuing education.
Could you please let me know the following?

1. Is Whiplash Injury Causation and Best Treatment Methods Taught as part of the core curriculum to Ontario Physicians during residency or medical school? - We offer professional development opportunities related to the business side of medicine. We do not offer CME on any clinical topics. That said, I am not sure the answer to your question. I would agree with Jeff that you may want to reach out to one of the medical schools directly such as McMaster or, perhaps CaRMS may be an option. Here is a link:https://www.carms.ca/about/

2. Is Pain Management taught as part of the core curriculum to Ontario Physicians during residency or medical school? If yes, is this multidisciplinary pain management or interventional or both? See above

3. If whiplash and multidisciplinary pain management are not taught to your members during their schooling, do you offer a "partnership type agreement" in order to provide this education to your members through my CME program? You could check with the College of Family Physicians of Canada to see if any group is offering this type of CME program and posted it on their calander of events: https://www.cfpc.ca/en/education-professional-development/cpd-events-calendar. Note. This calendar would only display those events that the group offering the CME, wished to include on the calendar (it isn't mandatory to include an event). As well, for specialties other than Family Medicine, you may want to try the Royal College: https://www.royalcollege.ca/rcsite/events-e

Medical Schools in Ontario do **NOT** offer Whiplash Traumatology Training as part of their core curriculum.

- Only one Medical School in Ontario offers Continuing Medical Education on Whiplash Traumatology was McMaster Medical School.
- You can see from the screen shot attached below that the only program offered to Medical Doctors in Ontario on Whiplash Traumatology is one that I have developed and teach.

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McMaster University

Continuing Professional Development (CPD) Office

David Braley Health Sciences Centre
DBHSC 5007
1280 Main Street West
Hamilton, ON, Canada L8S 4K1

Phone: [redacted]
Fax:
Email:
Web: https://chse.mcmaster.ca/events/chse

November 17, 2021

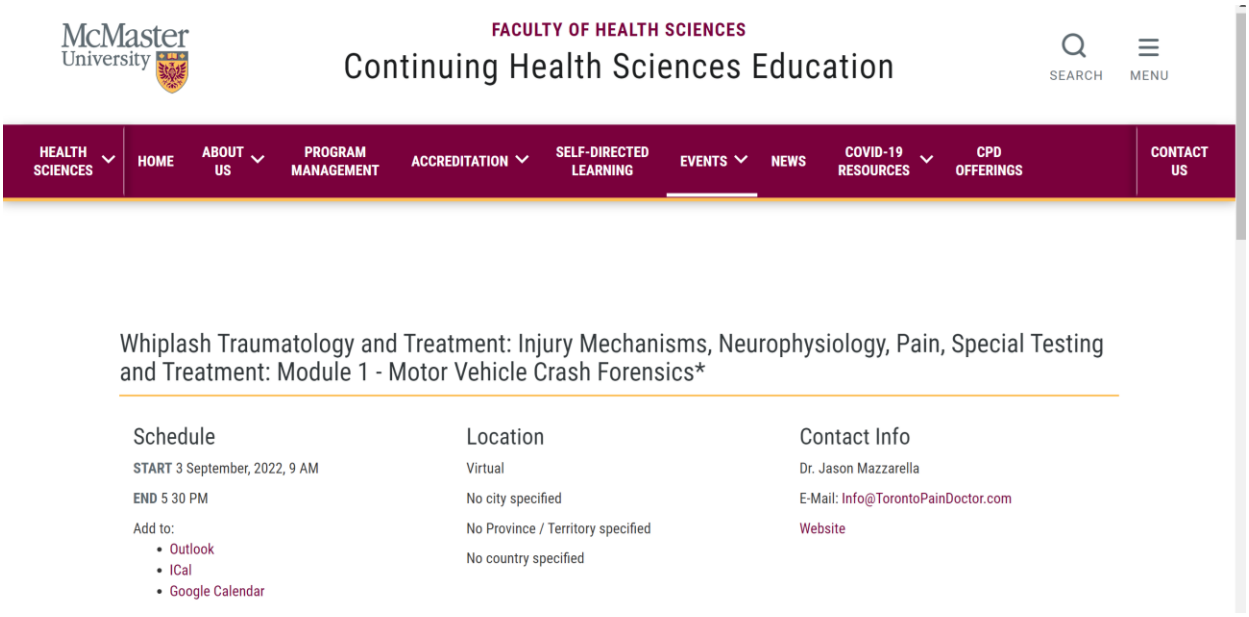
Dr. Jason Mazzarella
28 Finch Avenue West, Suite 212
Toronto, Ontario M2N2G7

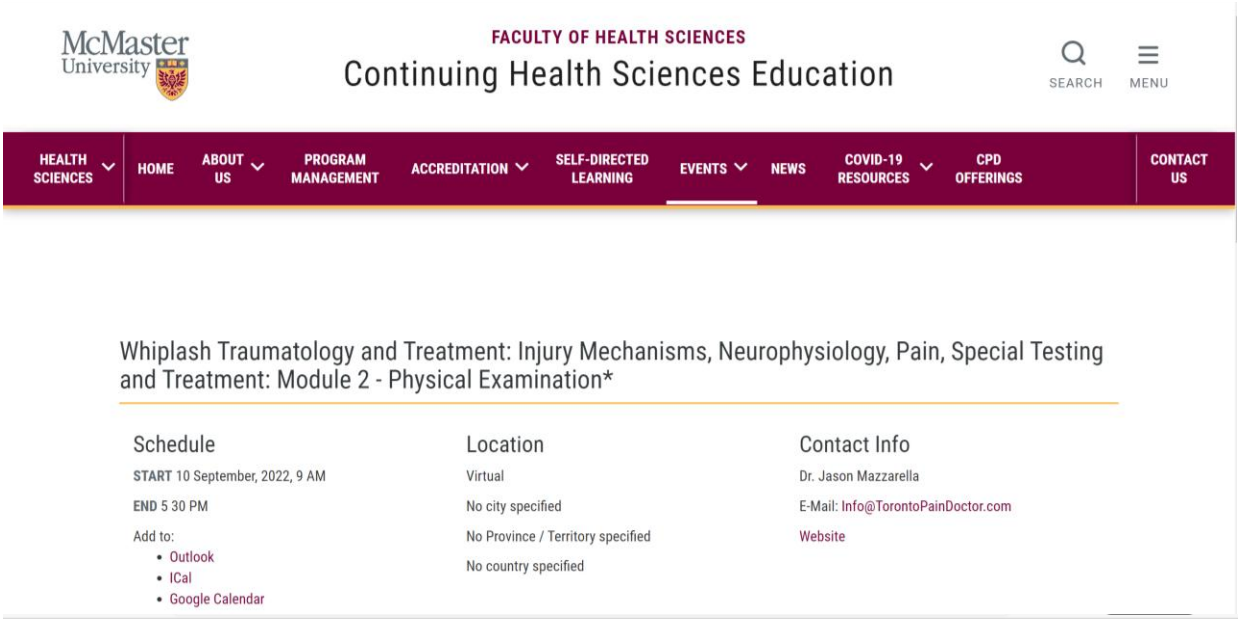
RE: Whiplash Traumatology and Treatment: Injury Mechanisms, Neurophysiology, Pain, Special Testing and Treatment

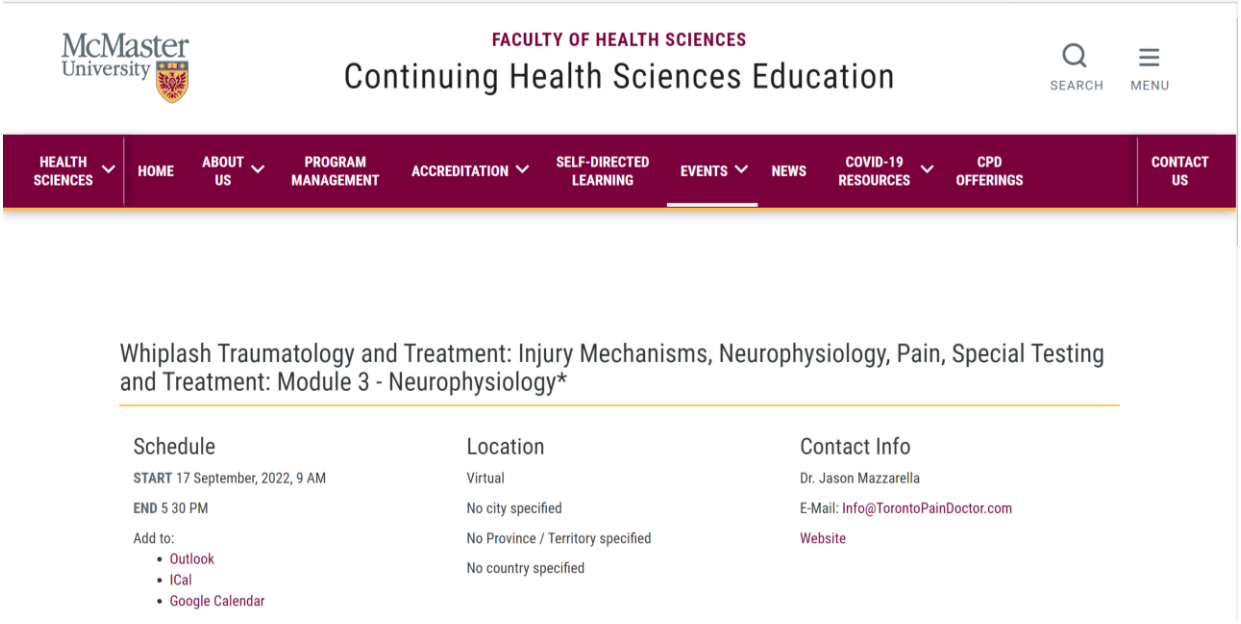
Dear Dr. Mazzarella,

We have reviewed the application for the Whiplash Traumatology and Treatment: Injury Mechanisms, Neurophysiology, Pain, Special Testing and Treatment Program to commence as of March 5, 2022. We are pleased to inform you that this program has received endorsement for the period from December 1, 2021 – November 30, 2023.

The Whiplash Traumatology and Treatment Program meets the standards, polices and ethical guidelines outlined in the McMaster CPD Guidebook for Planning, Developing and Delivering Continuing Health Sciences Education Activities. As per the







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Canadian Orthopedic Association (Email Correspondence November 16, 2021, at 1:18 PM)

- The Canadian Orthopedic Surgeons Association states that Whiplash Traumatology was outside the expertise of the Orthopedic Surgeons Specialty.
- **Canadian Orthopedic Association specifically states whiplash injuries are "OUTSIDE OF THE ORTHOPEADIC SPECIALTY" and "IT WOULD NOT BE COMPLAINT WITH THE ROYAL COLLEGE CERTIFICATION TO ACCREDITE OUTSIDE OF THE EXPERTISE OF OUR COMMITTEE."** This response was associated with a request of the Canadian Orthopedic Association to accredit a Whiplash Traumatology Continuing Education Program.

Gmail

Jason Mazzarella <info@torontopaindoctor.com>

FW: [EXTERNAL] Re: Accreditation Request

4 messages

COA [redacted]@canorth.org> Tue, Nov 16, 2021 at 1:18 PM
To: "info@torontopaindoctor.com" <info@torontopaindoctor.com>

Dear Dr. Mazzarella,

Thank you for this request. I am the primary contact for all course accreditations through the COA, [redacted] passed your email on to me.

I have consulted with our accreditation committee, and they have advised that they cannot proceed with accreditation for this course because it is outside of the orthopaedic specialty. It would not be compliant with our Royal College certification to accredit outside of the expertise of our committee.

Sorry to deliver the bad news, and let me know if you have any questions at all.

Warm regards,

[redacted]

[redacted]

Manager, Education and Professional Development / Directrice, Formation et perfectionnement

Canadian Orthopaedic Association / Association Canadienne d'Orthopédie

LinkedIn | Twitter

<u>Canadian Association of Physical Medicine and Rehabilitation (Email Correspondence April 12, 2022, at 2:42 PM)</u>

- The Canadian Association of Physical Medicine and Rehabilitation states that Whiplash Traumatology education is not offered by their association and that the individual medical schools would be responsible for this education.

FW: New Message From CAPM&R - Contact CAPM&R

2 messages

[redacted]@eventsmgt.com> Tue, Apr 12, 2022 at 2:42 PM
[redacted]doctor.com" <info@torontopaindoctor.com>

Dear Dr. Mazzarella,

Thank you for your inquiry. The education of undergraduate and post-graduate medical trainees is very much handled at the local level. Medical schools and residency programs are each responsible for their own curricula, which vary from setting to setting, and we are not sure what is addressed at each location. We would not be in a position as CAPMR to offer this education.

Best regards,

CAPMR

<u>*College of Family Physicians of Canada*</u>

In Ontario Family Physicians treatment of neck pain involves "not-Traumatic" neck pain, which we have shown above does NOT include Whiplash. In addition, the recommendations for Neck Pain as stated by the CFPC, include a multi model approach to care, especially if the pain is chronic. Please see number 3.

Neck Pain

	Key Feature	Skill	Phase
1	In patients with non-traumatic neck pain, use a focused history, physical examination and appropriate investigations to distinguish serious, non-musculoskeletal causes (e.g., lymphoma, carotid dissection), including those referred to the neck (e.g., myocardial infarction, pseudotumour cerebri) from other non-serious causes.	*Clinical Reasoning Selectivity*	*Hypothesis generation Diagnosis*
2	In patients with non-traumatic neck pain, distinguish by history and physical examination, those attributable to nerve or spinal cord compression from those due to other mechanical causes (e.g., muscular).	*Clinical Reasoning*	*History Physical*
3	Use a multi-modal (e.g., physiotherapy, chiropractic, acupuncture, massage) approach to treatment of patients with chronic neck pain (e.g., degenerative disc disease +/- soft neuro signs).	*Clinical Reasoning*	*Treatment*
4	In patients with neck pain following injury, distinguish by history and physical examination, those requiring an X-ray to rule out a fracture from those who do not require an X-ray (e.g., current guideline/C-spine rules).	*Clinical Reasoning Selectivity*	*Diagnosis Investigation*
5	When reviewing neck X-rays of patients with traumatic neck pain, be sure all vertebrae are visualized adequately.	*Clinical Reasoning*	*Diagnosis Investigation*

The College of Family Physicians of Canada Assessment Objectives for Certification in Family Medicine, 2nd Edition, May 2020.

College of Chiropractors of Ontario

THIRD PARTY INDEPENDENT CHIROPRACTIC EVALUATIONS. Standard of Practice S-018
Quality Assurance Committee

Assessor Qualifications

An ICE shall:

- be registered in the 'General' class of registration and be providing clinical care in Ontario;
- only perform independent chiropractic evaluations and file reviews within his/her area of expertise and within the scope of practice of chiropractic as defined in the *Chiropractic Act, 1991*;
- have necessary and relevant education, training, experience, and expertise to offer an opinion regarding the issue in dispute;
- maintain professional liability protection as outlined in Regulation R-137/11 ~~R-003~~: Registration, and CCO By-law 16: Professional Liability Insurance;

- **The College of Chiropractors of Ontario requires that the Independent Chiropractic Examiner have, "have necessary and relevant education, training, experience, and expertise to offer an opinion regarding the issue in dispute." Based on this definition to give the insured as much consideration as the insurer, a ICE would have to have equal or greater training in "Whiplash". Hiring a doctor with less training in my opinion would be considered a Deceptive Act.**

Dr. Jason Mazzarella
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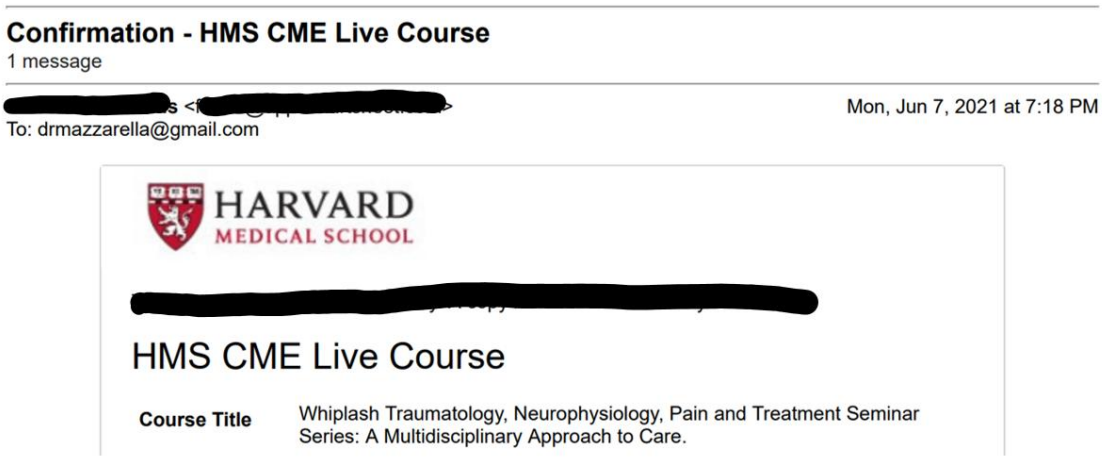
Toronto, Ontario M2N2G7

Tel: 416.628.1336
Email: DrMazzarella@gmail.com
www.DrMazzarella.com

<u>This understanding that Whiplash Traumatology is not taught in Medical Schools is NOT limited to Canada</u>

<u>Harvard Medical School</u>

I have been in discussions and am currently in discussions with Harvard Medical School to offer my Whiplash Traumatology and Treatment Continuing Education program through their university.



Confirmation - HMS CME Live Course
1 message

[redacted] Mon, Jun 7, 2021 at 7:18 PM
To: drmazzarella@gmail.com

HARVARD MEDICAL SCHOOL

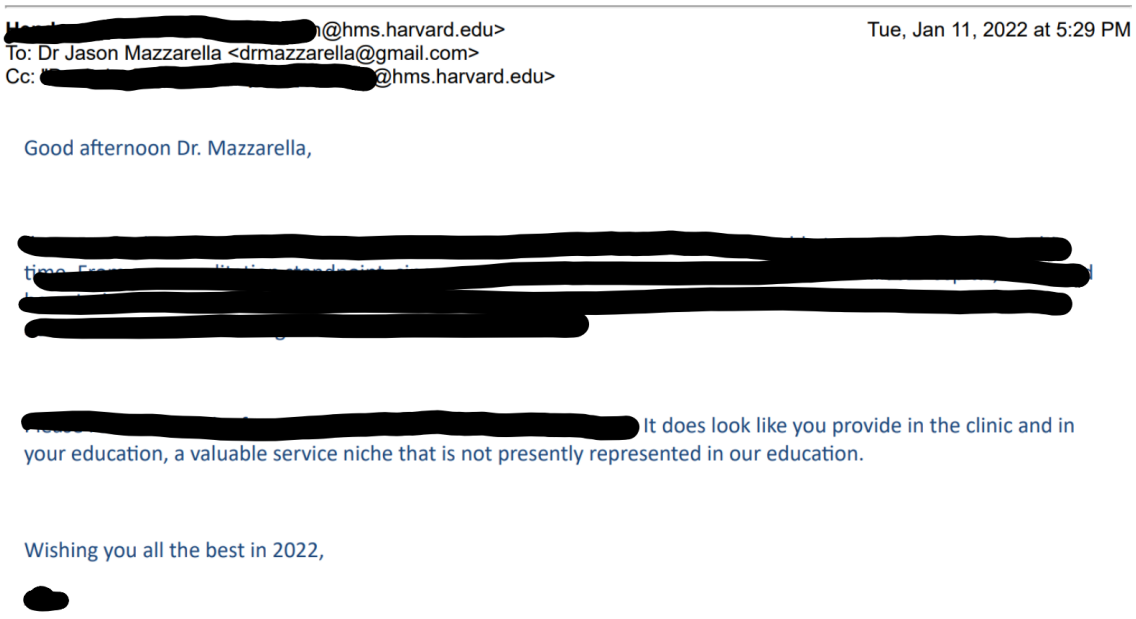
[redacted]

HMS CME Live Course

Course Title Whiplash Traumatology, Neurophysiology, Pain and Treatment Seminar Series: A Multidisciplinary Approach to Care.

In response to my request, Harvard Medicine provided the following reply.

"It DOES look like you provide in clinic and in your education, a valuable service niche that is **<u>NOT</u>** <u>presently represented in our education</u>."



[redacted]@hms.harvard.edu> Tue, Jan 11, 2022 at 5:29 PM
To: Dr Jason Mazzarella <drmazzarella@gmail.com>
Cc: [redacted]@hms.harvard.edu>

Good afternoon Dr. Mazzarella,

[redacted]

[redacted] It does look like you provide in the clinic and in your education, a valuable service niche that is not presently represented in our education.

Wishing you all the best in 2022,

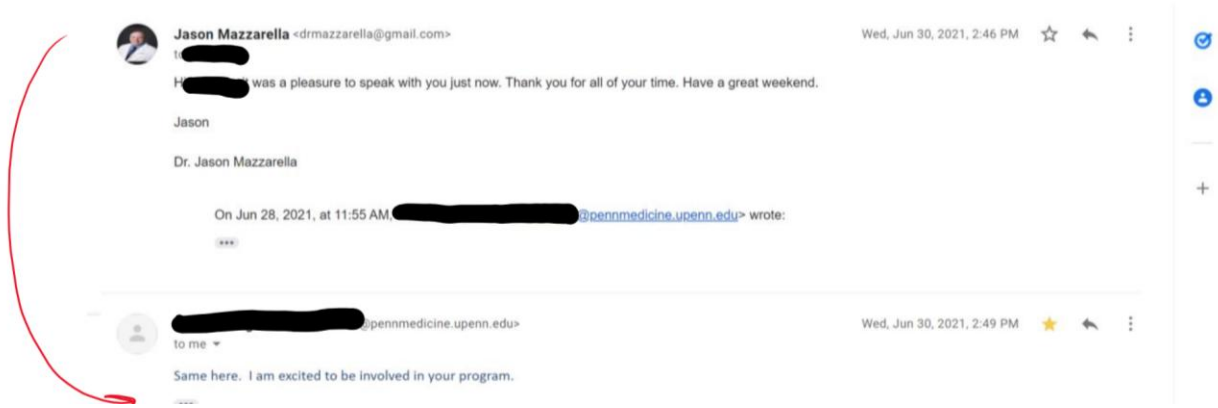
[redacted]

<u>University of Pennsylvania School of Medicine</u>

I have been in discussions and am currently in discussions with the University of Pennsylvania School of Medicine to also offer my Whiplash Traumatology and Treatment Continuing Education program through

their university.

In response to my CME request, the University of Pennsylvania School of Medicine provided the following reply based on the lack of Whiplash Specific training in the medical profession. The University of Pennsylvania School of Medicine stated, “I am excited to be involved in your program”, referring to my Whiplash Traumatology, Neurophysiology, Pain and Treatment Seminar Series: A Multidisciplinary Approach to Care



In fact, my continuing education program is currently the **ONLY Medically Accredited Program in the World on Whiplash Traumatology and Treatment.**

College of Osteopathic Medicine
MICHIGAN STATE UNIVERSITY

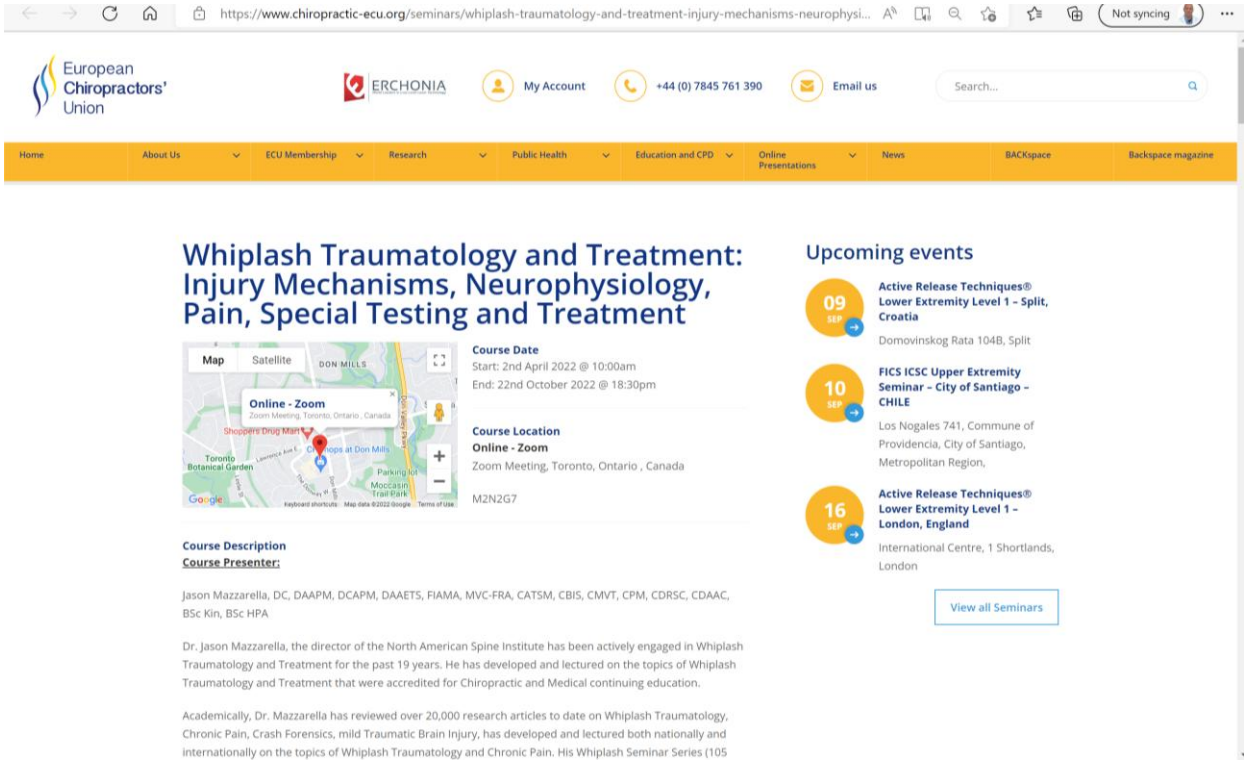
August 12, 2021

Jason Mazzarella, DC
28 Finch Avenue West, Suite 212
Toronto, Ontario M2N2G7

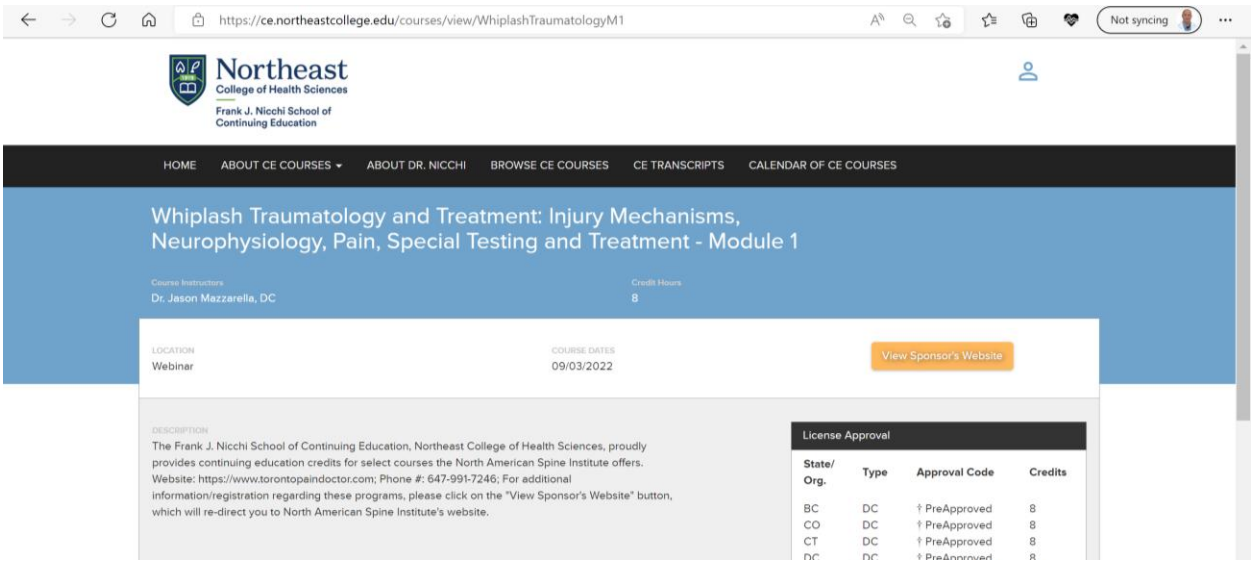
Dr. Mazzarella,

Your request for accreditation of the “**Whiplash Traumatology and Treatment**” series which begins **March 5, 2022**, has been approved by the Michigan State University College of Osteopathic Medicine Office of Continuing Medical Education, for up to ***31.75 AMA PRA Category 1 Credit(s)™***.

And is also the ONLY Accredited Chiropractic Program on Whiplash in multiple countries, 29 to be exact.



https://www.chiropractic-ecu.org/seminars/whiplash-traumatology-and-treatment-injury-mechanisms-neurophysiology-pain-special-testing-and-treatment/



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North American Spine Institute

Whiplash Traumatology and Treatment: Injury Mechanisms, Neurophysiology, Pain, Special Testing and Treatment - Module 1 Credits: 8

NASIm1W 9/3/2022 - 9/3/2022 Webinar,

State	Status	Topic	Category	Lic. Type	Valid Dates	Credits
BC	PreApproved	--	Unspecified	DC	1/1/2000 - 12/31/2999	8
CO	PreApproved	--	Unspecified	DC	1/1/2000 - 12/31/2999	8
CT	PreApproved	--	Unspecified	DC	1/1/2000 - 12/31/2999	8
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LA	Not Accepted	--	Unspecified	DC	1/1/2000 - 12/31/2999	8
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NH	PreApproved	--	Unspecified	DC	3/1/2021 - 12/31/2999	8
NJ	PreApproved	Principles of Practice of Chir	General	DC	9/1/2019 - 8/31/2023	8
NY	Approved	Clinical Interventions / Evide	General	DC	3/1/2022 - 2/28/2025	8
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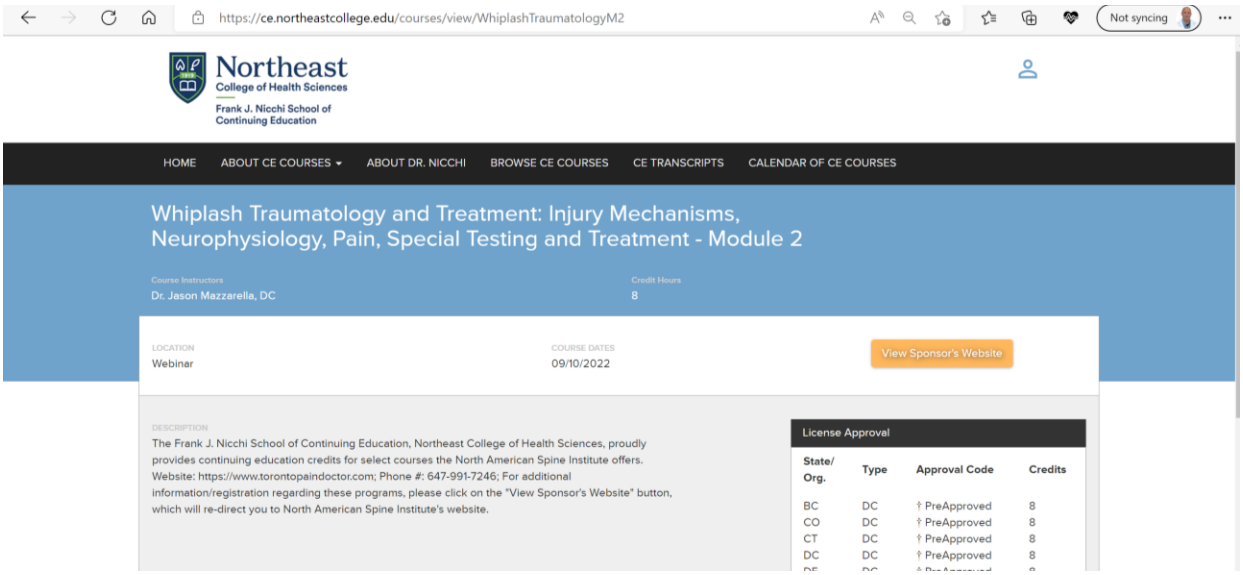

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North American Spine Institute

Whiplash Traumatology and Treatment: Injury Mechanisms, Neurophysiology, Pain, Special Testing and Treatment - Module 2 Credits: 8

NASIm2W 9/10/2022 - 9/10/2022 Webinar,

State	Status	Topic	Category	Lic. Type	Valid Dates	Credits
BC	PreApproved	--	Unspecified	DC	1/1/2000 - 12/31/2999	8
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NJ	PreApproved	Principles of Practice of Chir	General	DC	9/1/2019 - 8/31/2023	8
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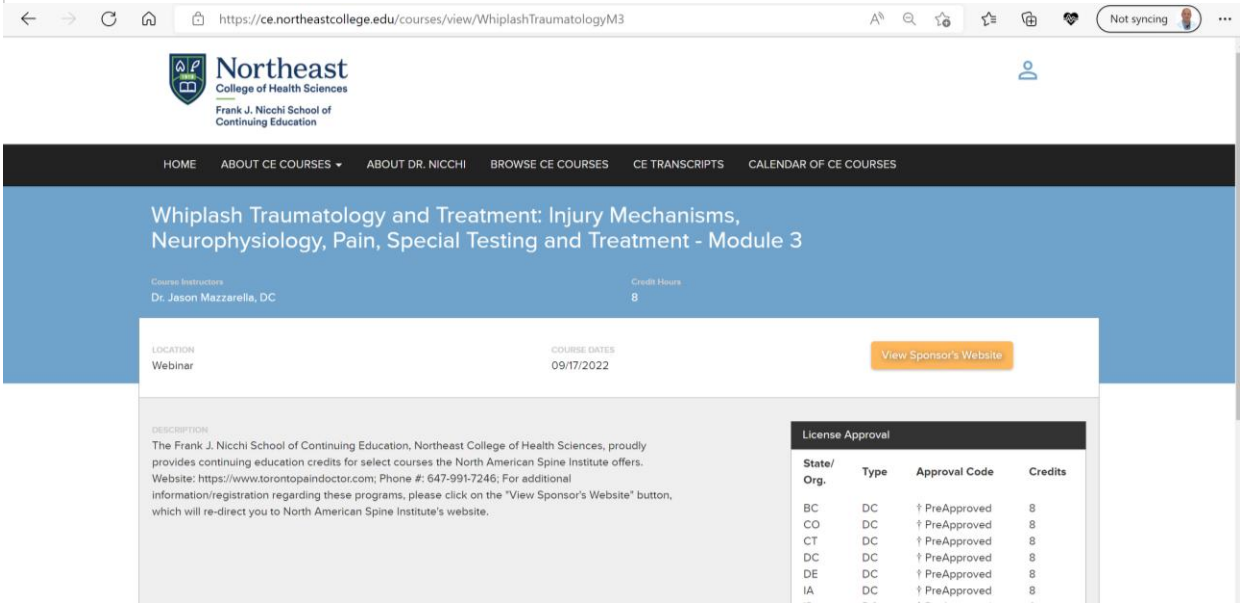

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North American Spine Institute

Whiplash Traumatology and Treatment: Injury Mechanisms, Neurophysiology, Pain, Special Testing and Treatment - Module 3 Credits: 8

NASIm3W 9/17/2022 - 9/17/2022 Webinar,

State	Status	Topic	Category	Lic. Type	Valid Dates	Credits
BC	PreApproved	--	Unspecified	DC	1/1/2000 - 12/31/2999	8
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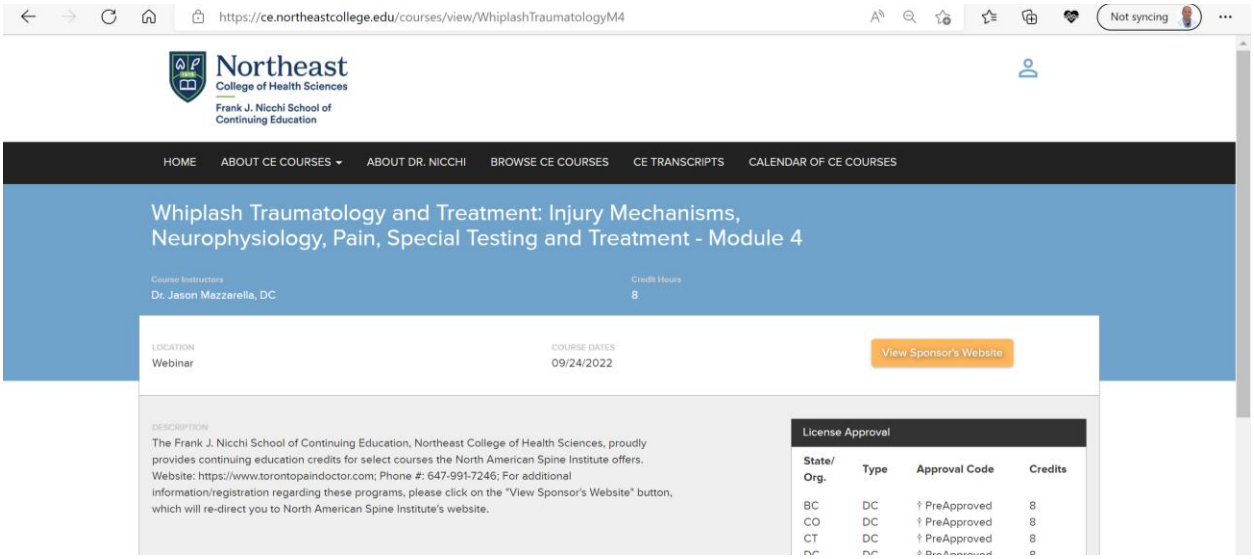

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North American Spine Institute

Whiplash Traumatology and Treatment: Injury Mechanisms, Neurophysiology, Pain, Special Testing and Treatment - Module 4 Credits: 8

NASIm4W 9/24/2022 - 9/24/2022 Webinar,

State	Status	Topic	Category	Lic. Type	Valid Dates	Credits
BC	PreApproved	--	Unspecified	DC	1/1/2000 - 12/31/2999	8
CO	PreApproved	--	Unspecified	DC	1/1/2000 - 12/31/2999	8
CT	PreApproved	--	Unspecified	DC	1/1/2000 - 12/31/2999	8
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NATIONAL UNIVERSITY OF HEALTH SCIENCES
CONTINUING EDUCATION MASTER PROCESSING SERVICES AGREEMENT

THE NATIONAL UNIVERSITY OF HEALTH SCIENCES (the "University" or "NUHS") and [North American Spine Institute] ("Teaching Organization") enter into this Agreement (referred to as "Agreement" or "Contract" herein) with the terms and stipulations set forth below. NUHS and Teaching Organization may be collectively referred to as the "Parties" or individually referred to as a "Party" herein.

Dr. Jason Mazzarella
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Tel: 416.628.1336
Email: DrMazzarella@gmail.com
www.DrMazzarella.com

If to Teaching Organization:
Teaching Organization agrees to accept all notices, as outlined above, at the address listed in Teaching Organization's CE Seminar Application, which is incorporated herein as Addendum A.

IN WITNESS WHEREOF, this Agreement has been executed by the duly authorized representative of the Parties as of the day and year first above written.

National University of Health Sciences

By: Dr. Randy Swenson

Title: VP for Academic Services

Signature: [redacted]

Date: 1/5/2022

Teaching Organization

Name of Organization: North American Spine Institute

By: Dr. Jason Mazzarella

Title: Director

Signature: [redacted]

Date: 1/5/2022

See attached outline of my world recognized and accredited Whiplash Traumatology, Neurophysiology, Pain and Treatment Seminar Series: A Multidisciplinary Approach to Care seminar series. The only education program offered in 29 countries on whiplash traumatology that is accredited for Medical, Chiropractic, Physical Therapy and Massage Therapy continuing education credit.

This accreditation and seminar make my opinion the current and only academic opinion on Whiplash at the time of this document's publication. Please see attached Seminar outline for a full description of all topics discussed and taught in this internationally accredited Whiplash Seminar.

- **In Graul v. Kansal, 2022 ONSC 1958, Justice G.D. Lemon stated that "teaching" the material to other doctors was a key factor in determining expert qualification**

Whiplash Traumatology Expert

In Michigan case Craig vs. Oakwood Hospital decided by the Michigan Supreme Court on July 23rd, 2004. They held that an expert witness under 702 to meet the requirements of Daubert, and one of the requirements that's stated in that case is that the Court, in considering the qualification of an expert witness, must at a minimum evaluate the following:

- The educational and professional training of the expert witness, the area of specialization of the expert witness, and, this is the crux, the length of time the expert witness has been engaged in the active practice of the specialty.
    - This active specialty is based on the injury mechanics is Whiplash (WAD).
    - Please see my attached CV. My CV will show a specialization in Whiplash and Chronic Pain, Vestibular Injuries and qEEG.

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- Although the Supreme Court in Craig referred to additional requirements, beyond those set forth in MRE 702, for a witness to be qualified as an expert, those additional requirements were based on MCL 600.2169, which requires that a medical expert be licensed and have devoted a majority of his or her professional time to the active clinical practice of the profession during the ***year preceding the alleged malpractice.***

    - I have been active in Whiplash Traumatology Assessment, Diagnosis, Treatment and Education since the early 2000's to present day.

    - To date I have assessed and treated over 50,000 MVA patients and am currently in active practice treating these patients at the time of this documents production.

- Please remember Whiplash Traumatology (Assessment, Diagnosis and Treatment) is NOT taught in any Medical Professional School and I am the ONLY doctor in Canada currently accredited to teach Whiplash Traumatology all Healthcare Providers. I have been accredited to do so since 2008 (length of time as an expert = 15 years, see below).

Dr. Jason Mazzarella's Continuing Education Programs: Whiplash Traumatology and Treatment Program Accreditation and Endorsement.

- 2008-2010: Whiplash Treatment & Traumatology: A Multidisciplinary Approach to Care. (Approved 105 CCE, CME and AAFP continuing education hours of training.)
- Academic Endorsement and/or Accreditation
- *University at Buffalo School Medicine and Biomedical Sciences*
- *The American Academy of Family Physicians*
- *The American Chiropractic Association*
- *National University of Health Sciences*

- 2021-2024: Whiplash Traumatology, Neurophysiology, Pain and Treatment Seminar Series: A Multidisciplinary Approach to Care. (Approved 32 CCE and CME continuing education hours of training in 29 countries.)
- Academic Endorsement and/or Accreditation
- *Michigan State University School of Medicine and Osteopathic Medicine*
- *National University of Health Sciences*
- *Northeast University of Health Sciences*
- *McMaster Medical School*
- *European Chiropractors' Union*

- 2024-Present: Whiplash Traumatology, Neurophysiology, Pain and Treatment Seminar Series: A Multidisciplinary Approach to Care. (Approved 32 CCE continuing education hours of training in 29 countries.)
- Academic Endorsement and/or Accreditation
- *National University of Health Sciences*
- *European Chiropractors' Union*

Additional information for consideration: Specific Medical Scope Considerations for IME services.

The College of Physicians and Surgeons of Ontario state in their Third-Party Medical Reports Policy, that physicians must "accurately represent their scope of practice and area of expertise, including their qualifications, in accordance with relevant College policy and regulation; and b. **restrict their IMEs,**

statements, and/or opinions to matters that are within their scope of practice and area of expertise." [1]

The CPSO states that an **active member** may practise only in the areas of medicine in which that active member is educated and experienced.

According to the Medicine Act, 1991, S.O. 1991, c. 30

CPSO Policy: ENSURING COMPETENCE: CHANGING SCOPE OF PRACTICE AND/OR RE-ENTERING PRACTICE. "Scope of practice is a term that describes a physician's practice at a particular point in time. A physician's scope of practice is determined by a number of factors including:"

- education, training, and certification;
- the patients the physician cares for;
- the procedures performed;
- the treatments provided;
- the practice environment

    - https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Ensuring-Competence

The Register from the College of Physicians and Surgeons of Ontario has stated, "We must ensure the doctor has appropriate training, education, and experience" specifically in whiplash traumatology and chronic pain, "otherwise this allows for what is called "practice drift". This "drifting" occurs when providers comment on areas of injury that fall outside the health care providers formal training or current practice experience. The phenomenon of "practice drift" is well recognized and has become an area of concern for regulators in Ontario. Dr. Rocco Gerace, College of Physicians and Surgeons of Ontario Registrar statement regarding Practice Drift, "We know that appropriate training leads to practice competency and that those without appropriate current training are more likely to have trouble maintaining an appropriate standard of care." Practice Drift allows for under treatment, mistreatment, and misdiagnosis. And this understanding is the basis of the policies and procedures the insurer has in place to Systemically Discriminate against Chiropractic, with the calculated risk that this will result in overall claim cost reduction.

THIRD PARTY MEDICAL REPORTS: June 2021: *https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Third-Party-Medical-Reports*

"Independent medical examinations (IME): Examinations that are conducted on individuals strictly for the purpose of a third-party process and not for the provision of health care."

- This means the completion of Third Party Independent Medical Examinations does not constitute a doctor patient relationship and thus cannot be considered as a "patient population" the assessing doctor treats just because they perform examinations. For a medical doctor to assess a whiplash and chronic pain patient within their scope of expertise they would have to provide therapy and treatment to whiplash and chronic patients in clinic.
- "Medical experts: Physicians who, by virtue of their medical education, training, skill and/or experience, have specialized knowledge and expertise on medical issues. They are retained by or on behalf of a party to provide opinion evidence in relation to a legal proceeding. Expert opinions are communicated by physicians in third party medical reports and/or testimony."
- I have established above that Whiplash Traumatology and Chronic Pain is not part of the doctor's medical education, training, skill and/or experience.

Please note, insurers typically report that "The License and Appeal Tribunal has repeatedly found that Insurers have a right to select their assessor of choice to conduct an IE, provided there is a nexus between the assessor's specialty and the injuries claimed." This shows that there is NO

nexus between the assessor's specialty and the injuries claimed, which were "Whiplash Injuries and Chronic Pain". Any suggestion that there is in my opinion would be a deceptive act and insurance fraud.

Conflicting Medical Reports or Recommendations: Ontario Human Rights Commission

"The Ontario Human Rights Commission states, "How to deal with conflicting medical reports or recommendations."

The OHRC states, "Employers should accept medical reports in good faith. In some cases, there may be conflicting information provided by two medical experts. For example, an employee's own doctor or specialist's report may outline different accommodation needs than an independent medical examiner's report."

While this is related to employer Medical Examinations, if the process is fair, impartial and objective, the same should apply to Insurance Independent Medical Assessments. In order to address each situation that the Ontario Human Rights council describes, my answers to their particular situations will follow.

"Deciding which report to follow will depend on the facts of the particular situation and the following kinds of factors:

- **What are the qualifications and degree of expertise of the two experts – which expert has more relevant experience?**

  Whiplash is not taught in the medical curriculum, and voluntary post graduate training is required in order to provide a component, objective opinion of need. This idea of voluntary post graduate training is listed in nearly every Whiplash Traumatology Guideline published since the 1990's and the idea that whiplash is not taught to any doctor in the core curriculum of Medical Schools is not a "novel" idea, but well accepted by the leading Medical Schools in the world, including Harvard Medical School.

  Dr. Jason Mazzarella Specific Training

  Dr. Mazzarella has developed a 105 hour Whiplash Traumatology and Treatment Continuing Medical Education program in 2008 that was accredited by the University at Buffalo School of Medicine, the American Academy of Family Physicians, the American Chiropractic Association and National University of Health Sciences, and a 32 hour Whiplash Traumatology, Neurophysiology, Pain and Treatment Seminar Series: A Multidisciplinary Approach to Care program that was accredited by the Michigan State University School of Medical and Osteopathic Medicine, McMaster Medical School, National University of Health Sciences, NorthEast University of Health Sciences and the European's Chiropractors Union.

  In addition, Dr. Jason Mazzarella has Specific Whiplash Traumatology and Chronic Pain Training including the following:

  - *Whiplash Traumatology:*

    - *Functional Anatomy: The Neck and Parotid Region*
    - *Robert Chase MD/Richard Sneil MD*
    - *Certified Motor Vehicle Trauma*
    - *Whiplash and Brain Traumatology Advanced Course 1995*
    - *Whiplash and Brain Traumatology Advanced Course 1996*
    - *Whiplash and Brain Traumatology Advanced Course 1997*
    - *Whiplash and Brain Traumatology Advanced Course 1998*
    - *Whiplash and Brain Traumatology Advanced Course 1999*

- *Whiplash and Brain Traumatology Advanced Course 2000*
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- *Whiplash and Brain Traumatology Advanced Course 2007*
- *Whiplash and Brain Traumatology Advanced Course 2008*
- *Whiplash and Brain Traumatology Advanced Course 2009*
- *Whiplash and Brain Traumatology Advanced Course 2010*
- *Whiplash - Aggressive Care May Delay Recovery in Whiplash*
- *Motor Vehicle Crash Forensics Risk Analysis Certification*
- *Advanced Medico-legal Seminar and Mock Trail*
- *Integrative Weekend*
- *Chiropractic Jurisprudence*
- *Diagnosis, Treatment, Rehabilitation: Clinical Case Management 1*
- *Diagnosis, Treatment, Rehabilitation: Clinical Case Management 2*
- *Record-keeping, Patient Exam and Documentation*
- *General Clinical Trauma Management*
- *Accident Imaging: X-ray, MRI, CT, VF and Analysis*
- *Understanding Mechanisms of Vehicular Accident Injury*
- *Principles of Soft Tissue Injury and Repair*
- *Trauma Neurology and Chiropractic*
- *New Era in Whiplash and Spinal Trauma - Part 2*
- *Whiplash and Brain Traumatology Module 1*
- *Whiplash and Brain Traumatology Module 4*
- *New Era in Whiplash and Spinal Trauma - Part 2*
- *Whiplash and Brain Traumatology Module 3*
- *Whiplash and Brain Traumatology Module 2*
- *Improving Functionability in Patients with Chronic Whiplash*

- *<u>Biomedical Engineering:</u>*

- *Biomedical Engineering with W Mark Saltzman- Biomechanics and Orthopedics*
- *Biomedical Engineering with W Mark Saltzman - Renal Physiology 2*
- *Biomedical Engineering with W Mark Saltzman - Renal Physiology*
- *Biomedical Engineering with W Mark Saltzman - Cardiovascular Physiology 2*
- *Biomedical Engineering with W Mark Saltzman - Cardiovascular Physiology*
- *Biomedical Engineering with W Mark Saltzman - Biomolecular Engineering: General Concepts 2*
- *Biomedical Engineering with W Mark Saltzman - Biomolecular Engineering: General Concepts*
- *Biomedical Engineering with W Mark Saltzman - Biomolecular Engineering: Engineering of Immunity.*
- *Biomedical Engineering with W Mark Saltzman - Biomolecular Engineering: Engineering of Immunity.*
- *Biomedical Engineering with W Mark Saltzman - Cell Communications and Immunology*
- *Biomedical Engineering with W Mark Saltzman - Cell Communications and Immunology*
- *Biomedical Engineering with W Mark Saltzman - Cell Culture Engineering*
- *Biomedical Engineering with W Mark Saltzman - Cell Culture Engineering*

- *Biomedical Engineering with W Mark Saltzman - Genetics Engineering*
- *Biomedical Engineering with W Mark Saltzman - Genetics Engineering*
- *Biomedical Engineering with W Mark Saltzman - Genetics*
- *Biomedical Engineering with W Mark Saltzman - What is Biomedical Engineering*

- *<u>Traffic Accident Reconstruction</u>*

- *Accident Investigation 2 - Includes: Vehicle damage analysis, Vehicle behavior, Lamp and Filament analysis, Tire damage analysis, measurement methods, interpretation of data and specialized data gathering.*
- *Accident Reconstruction Level 3 - Includes 80 contact hours of training. Topics include: Drag Factor determination, Grade and Super Evaluation determination, Speed Distance Determination, Skid to Stop distance, Negative Skid to Stop Distance Determinations, Roadway Evidence, Scaled Diagrams, Fall, Flip and Vault speed calculations, Yaw speed calculations, critical curve speed analysis, Dynamic testing, Vehicle Dynamics, Radius Determination, Lamp Examination, Tire Examination, Pedestrian Collision, Systematic Collision Investigation, Crush Analysis, Commercial Motor Vehicle Examination, Motorcycle Collision Analysis, Mock Fatal Crash Test.*
- *Accident Reconstruction Level 2 - Includes Drag Factor determination and Grade Evaluation, Speed Distance Determination, Skid to Stop distance, Negative Skid to Stop Distance Determinations, Roadway Evidence, Scaled Diagrams, At Scene Accident Photography, Dangerous Goods, Time Distance Measurements, Restraint System Evaluation, Tire Mark Evaluation (Skid Marks, Tire Marks, Imprints, Yaw Marks), Interview Techniques, Series of Events, and Vehicle Dynamics*
- *Accident Investigation AI 12*
- *Pedestrian Accidents: - Includes Includes: Determining impact points through vehicle evaluation and estimation of impact speeds based upon pedestrian movement and vehicle damage characteristics. Session with forensic pathologist regarding pedestrian injury patterns.*
- *Crash Data Analysis and Applications Certification*
- *Crash Data Retrieval Systems Operators (Technician) Certification*
- *Accident Investigation 1 - Includes: Preparation for traffic crash investigation, information from and about people, information from vehicles, information from roads, measuring and mapping the crash scene and photographing the crash scene and damaged vehicles.*

- *<u>Live Full-Scale Human Volunteer Crash Testing and High Speed Bio-Rid Dummy Vehicle and Pedestrian Crash Testing</u>*

- *Pedestrian Vehicle Deceleration Crash Testing*
- *Pedestrian Vehicle Acceleration Crash Testing*
- *Low Speed Human Volunteer and Bio-Rid Dummy Rear End Collision Testing*
- *Low Speed Human Volunteer and Bio-Rid Dummy Rear End Offset Collision Testing*
- *Low Speed Human Volunteer and Bio-Rid Dummy Front End Collision Testing*
- *Low Speed Human Volunteer and Bio-Rid Dummy Front End Offset Collision Testing*
- *Low Speed Human Volunteer and Bio-Rid Dummy Near Side Collision Testing*
- *Low Speed Human Volunteer and Bio-Rid Dummy Near Side Offset Collision Testing*
- *Low Speed Human Volunteer and Bio-Rid Dummy Far Side Collision Testing*
- *Low Speed Human Volunteer and Bio-Rid Dummy Far Side Offset Collision Testing*
- *High Speed Bio-Rid Dummy Near and Far Side Collision Testing*
- *High Speed Bio-Rid Dummy Front End Center and Offset Collision Testing*
- *High Speed Bio-Rid Dummy Rear End Center and Offset Collision Testing*

- *Testing: Accident Reconstruction and Investigation*

- *Mock fatal Pedestrian Collision*
- *Mock fatal Pedestrian Collision*
- *Dynamic Field Testing: Coefficient of Friction, Skid Distance, and Speed Analysis*
- *4 Wheel Independent Skid Mark Test*
- *Full Brake Overlapping Skid Mark Test with Shot Marker Test*
- *Rear Brake Motorcycle Skid Mark Test*
- *Rear Brake Skid Mark Test*
- *Vehicle Yaw Test, with Critical Curve Speed Analysis*

- *Pain Management Post Graduate Education*

- *Dr. Jeff Marksberry, MD, FAIS, CCRP. The Management of Anxiety, Insomnia, Depression and Pain with Cranial Electrotherapy Stimulation (CES) and Microcurrent Electrical Therapy (MET): Theory and Practice*
- *American Academy of Integrative Pain Management Non-Pharmacological Modulation of Chronic Pain*
- *American Academy of Integrative Pain Management Opioid-Induced Hyperalgesia*
- *American Academy of Integrative Pain Management Evidence Based Review of Dietary Supplements used to Treat Pain.*
- *University of Pennsylvania School of Medicine Pain and Relief Signals Muted in Fibromyalgia*
- *American Medical Association Module 12 Pain Management: Management of Cancer Pain: Other Analgesic and End-Of-Life Care*
- *American Medical Association Module 11 Pain Management: Pharmacotherapy for Cancer Pain*
- *American Medical Association Module 10 Pain Management: Overview and Assessment of Cancer Pain*
- *American Medical Association Module 9 Pain Management: Assessing and Treating Neuropathic Pain*
- *American Medical Association Module 8 Pain Management: Assessing & Treating Persistent Nonmalignant Pain: Common Persistent Pain Conditions*
- *American Medical Association Module 7 Pain Management: Assessing & Treating Persistent Nonmalignant Pain: An Overview*
- *American Medical Association Module 6 Pain Management: Pediatric Pain Management*
- *American Medical Association Module 5 Pain Management: Assessing & Treating Pain in Older Adults*
- *American Medical Association Module 4 Pain Management: Assessing & Treatment Pain in Patients with Substance Abuse Concerns*
- *American Medical Association Module 3 Pain Management: Barriers to Pain Management & Pain in Special Populations*
- *American Medical Association Module 2 Pain Management: Overview of Management Options*
- *American Medical Association Module 1 Pain Management: Pathophysiology of Pain and Pain Management*
- *Johns Hopkins University School of Medicine Challenges in the Assessment and Management of Chronic Pain: A Virtual CME Summit Series. Practical Strategies for Assessing and Diagnosing Neuropathic Pain.*

- *American Academy of Pain Management Integrative Approaches to Fibromyalgia: Part 2. Treatment of Fibromyalgia*
- *American Academy of Pain Management Integrative Approaches to Fibromyalgia: Part 1. Clinical Characteristics and Pathophysiology of Fibromyalgia*
- *University of Pennsylvania School of Medicine Spine Injections May Set Stage for Fractures*
- *University of Pennsylvania School of Medicine 3 Questions Help Docs Predict Pain Course*
- *Medscape No Offense Doctor, But I Want a Referral for My Pain*
- *Johns Hopkins University School of Medicine Challenges in the Assessment and Management of Chronic Pain: A Virtual CME Summit Series, "New Insights into the Pathophysiology & Assessment of Chronic Pain.*
- *University of Pennsylvania School of Medicine Inflammation Continues in Chronic Pain Patients.*
- *University of Pennsylvania School of Medicine Functional MRI can be used to Assess Pain*
- *University of Pennsylvania School of Medicine MRI for Low Back Problems Deemed "Overused"*
- *University of Pennsylvania School of Medicine Repeat MRI No Help After Sciatica Tx*
- *University of Pennsylvania School of Medicine Osteopathic Tx Ease Low Back Pain*
- *University of Pennsylvania School of Medicine Fibromyalgia Not One-Size Fits-All Disorder*
- *University of Pennsylvania School of Medicine Nerve Stimulation Cuts Down on Migraines*
- *University of Pennsylvania School of Medicine Brain Imaging Predicts Response to Depression Tx*
- *University of Pennsylvania School of Medicine Study: Check Brain Blood Flow in TBI*
- *University of Pennsylvania School of Medicine Phone Visits Speed Time to Physical Therapy*
- *University of Pennsylvania School of Medicine TV Before Bed May Rob Kids of Sleep*
- *University of Pennsylvania School of Medicine Painkillers May Protect Liver*
- *University of Pennsylvania School of Medicine Mild Head Injury Upset's Brain Resting State*
- *University of Pennsylvania School of Medicine Epidural Steroids Ineffective for Sciatica*
- *University of Pennsylvania School of Medicine Low Back Pain Eases but Doesn't Vanish*
- *University of Pennsylvania School of Medicine Vitamin D May Be of Help in Fibromyalgia*
- *University of Pennsylvania School of Medicine Brain Activity Reflects Pain in Fibromyalgia*
- *University of Pennsylvania School of Medicine Acupuncture Does help for Chronic pain*
- *University of Michigan School of Medicine Managing Patients with Chronic Non-Terminal Pain Including Prescribing Controlled Substances*
- *Johns Hopkins University School of Medicine Pain Management Virtual Congress 2012:*
- *Chronic Pain and Addiction: Does Everybody taking Opioids eventually become an addict?*
- *Johns Hopkins University School of Medicine Pain Management Virtual Congress 2012:*

- *Pain Management: Strategies for Balancing Patient, Physician and other Stakeholders Needs.*
- *Johns Hopkins University School of Medicine Pain Management Virtual Congress 2012:*
- *"Central Sensitization" Are Conditions like Fibromyalgia, Irritable Bowel Syndrome, and Interstitial Cystitis all Related?*
- *Johns Hopkins University School of Medicine Pain Management Virtual Congress 2012:*
- *Predictors of Chronic Pain: How Should the Case of Acute Pain be Formulated*
- *Johns Hopkins University School of Medicine Pain Management Virtual Congress 2012:*
- *Neuroimaging and Pain: Have we Really found the Soul of Suffering?*
- *American Academy of Family Physicians Principles of Neuropathic Pain Assessment and Management Pain*
- *American Academy of Family Physicians Tailoring the Treatment of Neuropathic Pain: Case Studies*
- *American Academy of Family Physicians Fibromyalgia in Family Medicine: Challenges in Pain Management*
- *Johns Hopkins University School of Medicine Pain Management Virtual Congress 2012:*
- *Rational Polypharmacy for Chronic Pain: What do all of these Medications Actually do for the Patient?*
- *Johns Hopkins University School of Medicine Pain Management Virtual Congress 2012:*
- *Chronic Pain Rehabilitation: The Basics of Changing Illness Behaviors*
- *University of Pennsylvania School of Medicine Insights into Pain Management: Module 7:*
- *Multidisciplinary Pain Management*
- *University of Pennsylvania School of Medicine Insights into Pain Management: Module 6:*
- *Use and Abuse of Opioid Analgesics*
- *University of Pennsylvania School of Medicine Insights into Pain Management: Module 5:*
- *Comprehensive Pharmacological Management of Pain*
- *University of Pennsylvania School of Medicine Insights into Pain Management: Module 4:*
- *Understanding Chronic Pain*
- *University of Pennsylvania School of Medicine Insights into Pain Management: Module 3:*
- *Understanding Acute Pain*
- *University of Pennsylvania School of Medicine Insights into Pain Management: Module 2:*
- *Assessment of the Patient with Pain*
- *University of Pennsylvania School of Medicine Insights into Pain Management: Module 1:*
- *Introduction into Pain*
- *American Academy of Family Physicians Diagnosis and Treatment of Acute and Chronic Low Back Pain with Leg Pain*
- *University of Chicago The Empathy Switch: How Doctors Regulate Pain Perception*
- *American Academy of Pain Management Pain and Brain 2: The Recognition and Management of Chronic Pain in Primary Care*

- *American Pain Society Pain: Pain Current Understanding of Assessment, Management, and Treatment.*
- *American Pain Society Pain: Section 5 Strategies to Improve Pain Management*
- *American Pain Society Pain: Section 4 Management of Acute Pain and Chronic Non-Cancer Pain*
- *American Pain Society Pain: Section 3 Types of Treatment*
- *American Pain Society Pain: Section 2 Assessment of Pain*
- *American Pain Society Pain: Section 1 Background and Significance*
- *American Academy of Family Physicians Managing Coexisting Pain and Depression*
- *American Academy of Family Physicians Practical Aspects of Chronic Pain Management: A Case based Approach.*
- *American Academy of Family Physicians Disparities in Care: Special Populations in Pain Management*
- *American Academy of Family Physicians Challenging Issues in Chronic Pain Management*
- *American Academy of Family Physicians Managing the Chronic Pain Patient at Risk or with a History of Addiction*
- *American Academy of Family Physicians Assessment and Management of Chronic Pain*
- *American Chiropractic Association Pain Management Treatment Options and Research*
- *American Academy of Experts in Traumatic Stress Certified in Pain Management*
- *University of Nebraska Medical School Pain Management with Opioid Analgesics*
- *Johns Hopkins University School of Medicine Pain and the Sensory System of RLS: XP13512 Treatment of RLS*
- *Johns Hopkins University School of Medicine Pain and the Sensory System of RLS: RLS Severity and Endogenous Opioids in the Medical Pain System*
- *Johns Hopkins University School of Medicine Pain and the Sensory System of RLS: Iron Dopamine Connection: Cellular Studies and Possible*
- *Johns Hopkins University School of Medicine Pain and the Sensory System of RLS: Pain and Sensory Disturbances in RLS: Prevalence and Clinical Significance.*
- *Beth Israel University Hospital Albert Einstein College of Medicine Overcoming Barriers to Pain Relief*
- *Medscape Treating Fibromyalgia Pain and Beyond: Pathophysiology and Management of Multiple Symptom Domains*
- *Medscape Sciatica and Low Back pain: Does Physical Therapy Provide Long-Term Benefits? A Best Evidence Review*
- *Memorial University Joint Adventures - Optimizing the Management of MSK Pain*
- *Memorial University Chronic Non Cancer Pain: Comprehensive Assessment and Management*
- *American Medical Association Pathophysiology of Pain and Pain Assessment*
- *American Medical Association Overview of Management Options*
- *American Medical Association Management of Cancer Pain: Other Analgesic Approaches and End of Life Care*
- *American Medical Association Cancer Pain: Pharmacotherapy*
- *American Medical Association Overview and Assessment of Cancer Pain*
- *American Medical Association Assessing and Treating Neuropathic Pain*
- *American Medical Association Assessing and Treating Persistent Nonmalignant Pain, Common Persistent Pain Conditions.*

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- *American Medical Association Assessing and Treating Persistent Nonmalignant Pain, An Overview*
- *American Medical Association Pediatric Pain Management*
- *American Medical Association Assessing and Treating Pain in Older Adults*
- *American Medical Association Assessing and Treating Pain in Patients with Substance Abuse*
- *American Medical Association Barriers to Pain Management and Pain in Special Populations*
- *Primed - American Medical Association Mechanism for Managing Chronic Pain*
- *Primed - American Medical Association Acupuncture in the Treatment of Low Back Pain*
- *Primed - American Medical Association Management Strategies for Patients with Moderately Severe Low Back Pain*
- *Primed - American Medical Association Managing Depression in a Patient with Pain*
- *Primed - American Medical Association Young Women Evaluated for Headache and Facial Pain*
- *Primed - American Medical Association Lower Extremity Pain in a Patient with Diabetes Mellitus*
- *University of Michigan School of Medicine Back Pain: Acute Low Back Pain in Adults*
- *Medscape American Academy of Pain Medicine 23rd Annual Meeting - Highlights of the American Academy of Pain Medicine 23rd Annual Meeting*
- *Medscape American Pain Society 26th Annual Scientific Meeting - Highlights of the American Pain Society 26th Annual Scientific Meeting.*
- *Medscape Breakthrough Pain: Strategies for Effective Assessment and the Role of Rapid-Onset Opiods in Treatment*
- *Medscape Undermanaged Pain in the Orthopedic Surgical Patient: Techniques to Improve*
- *Medscape Advances in Neuropathic Pain: Case Studies in Uncomplicated Postherpetic Neuralgia and Painful Diabetic Polyneuropathy*
- *Medscape Exercise in the Age of Evidence - Based Medicine: A Clinical Update*
- *Medscape Herbal Medicine May Be Effective for Low Back Pain*
- *Medscape Haloperidol Useful in Acute Treatment of Migraine*
- *AHC Media LLC- American Medical Association Relieving the Burden of Pain in Fibromyalgia*
- *Dannemiller Memorial Education Foundation Dialogues in Persistent Pain*
- *Dannemiller Memorial Education Foundation Musculoskeletal Pain Modules 2006*
- *Dannemiller Memorial Education Foundation The Association between Chronic Pain and Mood and Anxiety Disorder*
- *Dannemiller Memorial Education Foundation The Pain Processing Pathways*
- *NYCC Chiropractic Case Management of Acute & Chronic Pain Syndromes*
- *NYCC Appropriate Opioid Pharmacotherapy for Chronic Pain Management: Interactive LBP Case Study*
- *NYCC Appropriate Opioid Pharmacotherapy for Chronic Pain Management: Improving Functional Ability in Patients with Whiplash*
- *NYCC NPEC-Chronic Pain 411: Assessing the Chronic Pain Patient*

- **Were medical conclusions drawn based on lengthy visits over a number of months or was there only a 15-minute assessment?**

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My opinions are based on multiple in person treatments and examination over the course of 15 months. This supersedes the insurance doctor's singular interaction with the patient.

- **What methods were used for the assessment(s)?**

  My methods included Physical Examination, review of risk factors, continued monitoring of patient progression, patient assessment on a number of different occasions for jump sign, flexor response and hypersensitivity. Chronic Pain, Concussion, vestibular and qEEG special testing.

- **How far apart are the experts' opinions?**

  NA

- **What are the consequences of choosing one over the other?**

  Research has shown that whiplash is a leading cause of Chronic Pain. If the insured is denied care, the insured will be forced to use the OHIP system for pain management. This will most likley include the use of medications and injections in Lieu of physical medicine tretament options.

  Consequences of Opioid Usage in Lieu of Chiropractic Care:

  Studies show gray matter decrease in that region associated with the presence of chronic pain in as little as 30 days post usage. Studies provide important clues as to the mechanisms of morphine-induced morphologic changes, including modulation of neurogenesis, neuron cell density, number of proliferating cells, and apoptosis.

  - *Prescription opioid analgesics rapidly change the human brain. Younger JW, Chu LF, Arcy ND, Trott K, Jastrzab LE, Mackey S. Stanford University, School of Medicine. Pain. 2011 August ; 152(8): 1803–1810.*
  - *Gwilym SE, Fillipini N, Douaud G, Carr AJ, Tracey I. Thalamic atrophy associated with painful osteoarthritis of the hip is reversible after arthroplasty; a longitudinal voxel-based-morphometric study. Arthritis Rheum. 2010; 62:2930–40*
  - *Rodriguez-Raecke R, Niemeier A, Ihle K, Ruether W, May A. Brain gray matter decrease in chronic pain is the consequence and not the cause of pain. J Neurosci. 2009; 29:13746–50.*
  - *Teutsch S, Herken W, Bingel U, Schoell E, May A. Changes in brain gray matter due to repetitive painful stimulation. Neuroimage. 2008; 42:845–9.*

  Consequences of Lack of Pain Management due to unwarranted Denial based on Systemic Discrimination of Chiropractic:

- *Research has shown that Longitudinal experimental and observational studies have shown that pain-related morphological changes in the brain are reversible after cessation or successful treatment of the pain, however, this gray matter change is correlated with the duration of time since the trauma, not the severity or frequency of pain. Because of this, the longer the person is prevented from receiving appropriate whiplash traumatology treatment, the greater number of morphological changes occur and will continue to occur in the brain. These negative brain changes result in the following:*

    - *Bilateral Pre-Frontal Cortex*
      - *Symptoms:*
        - *Difficulty maintaining focus*
        - *Difficulty with coherent speech.*
      - *Right Thalamus*
        - *Difficulty with motivation*

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        - *Difficulty with wakefulness*
        - *Difficulty with arm/leg control.*
    - *Posteriolateral Thalamus*
        - *Poor mood control*
        - *Difficulty with motivation*
    - *Dorsolateral Pons*
        - *Issues with*
            - *Breathing*
            - *Taste*
            - *Hearing*
            - *Balance*
    - *Somatosensory Cortex*
        - *Difficulty with processing sensory information from the body.*

- *Gwilym SE, Fillipini N, Douaud G, Carr AJ, Tracey I. Thalamic atrophy associated with painful osteoarthritis of the hip is reversible after arthroplasty; a longitudinal voxel-based-morphometric study. Arthritis Rheum. 2010; 62:2930–40*
- *Apkarian AV, Sosa Y, Sonty S, Levy RM, Harden RN, Parrish TB, Gitelman DR. Chronic back pain is associated with decreased prefrontal and thalamic gray matter density. J Neurosci. 2004 Nov 17;24(46):10410-5*

Life Consequences of Inadequate Pain Management

Without fair consideration of a Whiplash Traumatology Specific Chronic Pain management the above noted negative cascade of brain morphological changes will continue. This uncontrolled pain continues to be the single most common cause of disability among working-age adults in Canada. Sixty per cent of people with chronic pain eventually lose their job, incur loss of income or will have a reduction in responsibilities as a result of their pain. This can ultimately result in increased taxpayer stress through publicly funded assistance programs, specifically due to deflection of private sector insurance carriers cost onto publicly funded assistance programs.

- *Barnsley L, Lord S, Boguk N: Clinical Review: Whiplash Injury. Pain 58 (1994) 283-307*
- *Upadhyay J, Maleki N, Potter J, Elman I, Rudrauf D, Knudsen J, Wallin D, Pendse G, McDonald L, Griffin M, Anderson J, Nutile L, Renshaw P, Weiss R, Becerra L, Borsook D. Alterations in brain structure and functional connectivity in prescription opioid-dependent patients. Brain. 2010; 133:2098–114*
- *The need for a Canadian pain strategy. Mary E. Lynch, MD, FRCP, Canadian Pain Society. Pain Res Manag. 2011 Mar-Apr; 16(2): 77–80*

- **If there are serious risks associated with a disability, it may be better to go with the "safer" accommodation. For example, one expert says the employee may have a heart attack if accommodation is not made and the other says accommodation is not necessary. It may be prudent to rely on the first opinion.**

  See above. There is no dispute that a pain process and injury is present, even the insurance IME doctor noted that the patient has chronic sacroiliitis that requires an MRI evaluation. Simple and basic whiplash and pain neurophysiology shows that only negative morphological changes will occur to the persons brain and neurological system if appropriate treatment is not provided, and this will coincide with negative neuroendocrine changes that will continue to occur based on the stress response associated with trauma and injury. These are medical facts, not opinions, as such there is a serious risk to the patient if a proper evaluation is not completed.

Appendix E: Potential for Bias: Motivation for Insurance Systemic Discrimination and Bad Faith against Chiropractic

Potential for Bias: Motivation for Insurance Systemic Discrimination and Bad Faith against Chiropractic through the use of Medical Doctors determining if Chiropractic OCF 18 Submissions are warranted and necessary.

In 1987, United States District Judge Susan Getzendanner found the AMA and its co-defendants guilty of violating the Sherman Antitrust Act.

"During the court proceedings, it was reported that the plaintiffs, however, point out that the anecdotal evidence in the records favors chiropractors. The patients who testified were helped by chiropractors and not by medical physicians. Per Freitag, a medical physician who associates with chiropractors, has observed that patients in one hospital who received chiropractic treatments are released sooner than patients in another hospital in which he is on staff which does not allow chiropractors. John McMillian Mennell testified in favor of chiropractic. Even the defendants economic witness, Mr. Lynk assured that chiropractic outperformed medical physicians in the treatment of certain conditions, and he believe that was a reasonable assumption. But most of the defense witnesses, surprisingly, appeared to be testifying for the plaintiffs, chiropractors. The court went on to say that "there are too many references in the record to chiropractors as competitors to ignore."

This Supreme Court case provides the foundation for possible medical bias, consciously or subconsciously, which insurers know to exist, which can then be used to positively reduce claim cost and risk exposure, leading to systemic discrimination of the Chiropractic Profession by having Medical Doctors determine the necessity of a Chiropractic Treatment Plan. Please see a detailed description below.

AMA attempt to contain and eliminate chiropractic – leading to Wilk v. AMA Supreme Court Ruling

"During the 1800s, there were a variety of medical sects vying for market share in the United States. Homeopaths, eclectics, naturopaths, and osteopaths, as well as the so-called "regular" orthodox medical practitioners, all had a stake in shaping the dominant health care paradigm." "The medical practitioners organized the American Medical Association in 1847 with the primary goals of standardizing medical education and instituting a program of medical ethics. By 1849, the AMA had taken on the role of investigating the various competing sects of medicine and challenging them on the basis of their ethics. The AMA took the position that the other forms of medicine, including the newly discovered chiropractic profession, were unethical and "unscientific." Many authors, however, have made the argument that the AMA's intent was to decrease competition for financial reasons rather than to protect the public from unethical practitioners." "Medical doctors from this fledgling group broadcast the message that their practice alone was scientifically based, despite the fact that their approach to medicine was no more scientific than that of the professions they were competing with."

"Not coincidentally, the AMA's efforts resulted in the transformation of American medicine from a modest, even menial profession into one of sovereignty, power, and financial affluence. By convincing state legislators that their profession was scientific while all others were not, the AMA and its state member associations were able to gain protection in the form of endorsement for educational programs and laws that limited "irregular" practice. The system of schools and hospitals, as well as the legislation protecting them, led to a "golden age of doctoring" that lasted until the 1970s. Orthodox or "allopathic" medicine enjoyed virtually complete dominance of the health care market in the United States. With the exception of chiropractors, competing professions shrank to nonexistence or were absorbed into the orthodox medical profession, as in the case of osteopaths. From its inception, chiropractic was looked upon as a menace by medical authorities."

"The AMA committee adopted a plan that was devised in 1962 by the Iowa Medical Society under the leadership of Robert B. Throckmorton. The so-called "Iowa Plan" outlined the "containment of the chiropractic profession" that "will result in the decline of chiropractic." "The massive scope and

methodical nature of this plan were exposed in hundreds of thousands of pages of AMA documents that were brought to light in the 1976 trial Chester C. A. Wilk et al. v. AMA et al."

"AMA writers ghostwrote television and movie scripts, as well as Ann Landers' widely read newspaper column and any other media outlet that could be used to tarnish the reputation of chiropractic in the public eye. The AMA even encouraged the distribution of anti-chiropractic materials to high school guidance counselors so they would dissuade interested students from pursuing careers in it. During the 11-year court battle that ensued, the AMA settled three lawsuits by relaxing its position on the referral of patients to chiropractors by medical doctors. In 1980, the AMA revised its Principles of Medical Ethics to reflect this new position, allowing medical doctors to be free to choose the patients they served, the environment they served in, and the other types of practitioners they associated with."

"In 1987, United States District Judge Susan Getzendanner found the AMA and its co-defendants guilty of violating the Sherman Antitrust Act. In her decision, Getzendanner asserted that "the AMA decided to contain and eliminate chiropractic as a profession" and that it was the AMA's intent "to destroy a competitor"

- *Agocs S: Chiropractic's Fight for Survival. AMA Journal of Ethics. Illuminating the Art of Medicine. 2011;13(6):384-388*
- *Getzendanner S. Permanent injunction order against AMA. JAMA. 1988;259(1):81-82.*

Results of Wilk v. American Medical Association

"On September 25, 1987, Getzendanner issued her opinion that the AMA had violated Section 1, of the Sherman Act, and that it had engaged in an unlawful conspiracy in restraint of trade "to contain and eliminate the chiropractic profession." (Wilk v. American Medical Ass'n, 671 F. Supp. 1465, N.D. Ill. 1987). She further stated that the "AMA had entered into a long history of illegal behavior". And, she then issued a permanent injunction against the AMA under Section 16 of the Clayton Act to prevent such future behavior."

- *Wilk v. American Medical Association, 895 F.2d 352 (7th Cir. 1990)*

On February 7, 1990, the Court of Appeals found the AMA guilty. On November 26, 1990, the U.S. Supreme Court upheld the trial court and the Court of Appeals' finding. In January of 1992, the final settlement took place between the AMA and the plaintiffs to complete all terms of the court order, thus ending one of the longest antitrust legal battles in the history of the United States. The result of this lengthy court battle was that the AMA "adopted the following statement, which is current today:

AMA's New Statement on Chiropractic -- Printed in the American Medical News, January 13, 1992. Revised Paragraph 3.08 of the Current Opinions of the Council on Ethical and Judicial Affairs stated, CHIROPRACTIC. It is ethical for a physician to associate professionally with chiropractors. A physician may refer a patient for diagnostic or therapeutic service to a chiropractor. Physicians may also ethically teach in recognized schools of chiropractic."

Based on this discriminatory tactic for financial gain by the AMA, the primary and most powerful medical association in the world, in my opinion, any doctor that would have graduated or been educated by a doctor that was in medical school prior to 1992, would have a potential for an inherent bias towards Chiropractic, either intentionally or non-intentionally. I believe this is another deceptive tactic by insures to systemically discriminate against chiropractic, buy using medical doctors to adjudicate what is considered a "reasonable claim" for treatment that they themselves do not offer in their clinical practice, with a preconceived notion that some form of bias will remain from the AMA tactics throughout the 1900's.

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Appendix F: **Insurance Good Faith and Fair Dealings Understanding:**

There is an "implied covenant of good faith and fair dealing" understanding that exists by operation of law in every insurance contract between the insurance company and its policyholder. The duty of good faith requires an insurer to fairly investigate and assess an insured's claim and make coverage decision. An insurer must assess the merits of the claim in a "balanced and reasonable manner" [1]

1. Fidler v. Sun Life Assurance Co. of Canada, 2006 SCC 30 (S.C.C.) at para 63.
2. Shea v. Manitoba Public Insurance Corp., [1991] B.C.J. No. 711
3. Usanovic v. Penncorp Life Insurance Company (La Capitale Financial Security Insurance Company), 2017 ONCA 395

A common type of first party bad faith occurs when insurers refuse to pay claims after a personal injury has occurred in a motor vehicle accident. In some cases, insurers hire "experts" without specific training, education, or experience in treating whiplash and chronic pain patients to say that the damage/injury was "minor"– thereby improperly denying insurance coverage. In Chateau Chamberay, 108 Cal.Rptr.2d at 785; cf. Sprague v. Equifax, Inc., 166 Cal.App.3d 1012, 213 Cal.Rptr. 69, 79 (1985), fraudulent termination exists if insurer arranges "an inadequate medical examination, producing a false conclusion, which would form an apparently plausible basis for wrongfully terminating payments".

In addition, according to Hangarter v. Provident Life and Acc. Ins. Co., 373 F. 3d 998 - Court of Appeals, 9th Circuit 2004,"***when an insurer "use[s] the same [IME] on a continual basis," the medical examiner becomes "biased" because they "lose their independence."*** In addition, the insurers letter retaining the IME provider was written by an adjuster without whiplash or chronic pain specific training or medical training, who had never examined the patient, but claimed that there their injuries would fall under the Minor Injury Guideline. In the case above, this letter "bias[ed]" and "predispos[ed] the doctor" against finding disabling injuries by "telling him [Defendants'/Insurers] opinion" and in this same context, that the patient's injuries were "minor".

In this context, bad faith insurance claims arise when the insurer, after undertaking a fiduciary duty to protect their insured, fails to offer the full value of a claim to the injured party. By intentionally denying or underpaying claims, insurers can decrease insurance premiums, which allows them to capture more market share for people looking for the least expensive insurance rate, and we have seen this time and time again in the past, only to repeat itself today using the same policies and principles enacted in the 1990's that were described by the courts as systemic bad faith.

In my opinion, any reasonable person would conclude that the insurer is acting unreasonable and in bad faith by using a guideline that specifically stated, the sole purpose for its development was to reduce physical medicine claim costs, and that during its development and research which occurred between 1980 to 1993, "evidence regarding whiplash injury and treatment need was sparse and generally of unacceptable quality". Especially in light of more recent evidence presented above, and in our "research topics" section, as well as the auto insurers own funded guideline that says the usage of the Minor Injury is inappropriate and does not represent the full array of an injured persons injuries. Furthermore, it is my opinion by using a medical doctor to adjudicate a chiropractic treatment plan, as well as a doctor without specific training, education, and experience in whiplash and chronic pain, that the Independent Medical Examination (IME) the insurer arranged to wrongfully terminate benefits is bad faith and a violation of my Canadian Charter of Rights to fair employment.

I believe the text of this document solidifies my complaint of systemic discrimination against a profession for the sole purpose of financial gain which then violates by Canadian Charter of Rights to gainful employment.