Background Information:
Development of Deceptive Tactics intended to Systemically Discriminate against an entire profession for the sole purpose of claim cost reductions at the expense of the policy holder's health and well being.

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 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 with minimal vehicle damage 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 US courts. However, during that time span, insures profited to the tune of over 700 million dollars.

<u>Systemic Discrimination: History.</u>

- In the early 1990's 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.
- As part of the MIST program, adjusters were instructed to Deny, Delay, and then Defend claims. This was intentionally 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 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 Medical Hierarchy
    - 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.
    - 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 (see below).
- 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 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.
  - In Ontario Chiropractors are currently the only regulated health profession that is commonly reviewed by healthcare providers in a different healthcare discipline.
- 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 Chiropractors, the primary doctors treating whiplash 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 as I will show 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)

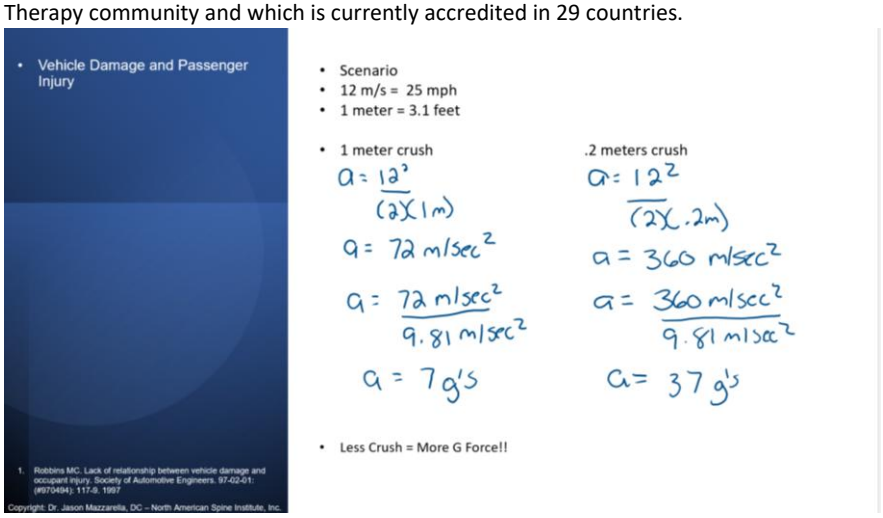
This ideology presented here and employed by Allstate (USA) in the 1990's is relevant, as the insurer is using the same discriminatory practices and principles designed and utilized by Colossus to adjudicate Ontario claims.

Background: No Crash No Cash Defense:

The no crash no cash defense first employed by Allstate in the 1990's suggested that motor vehicle collisions that resulted in minimal damage could not result in occupant injury. There was a suggestion that anyone reporting injuries in minimal damage collisions did so to defraud the insurer as no real injuries could be sustained if significant damage did not occur to the vehicle.

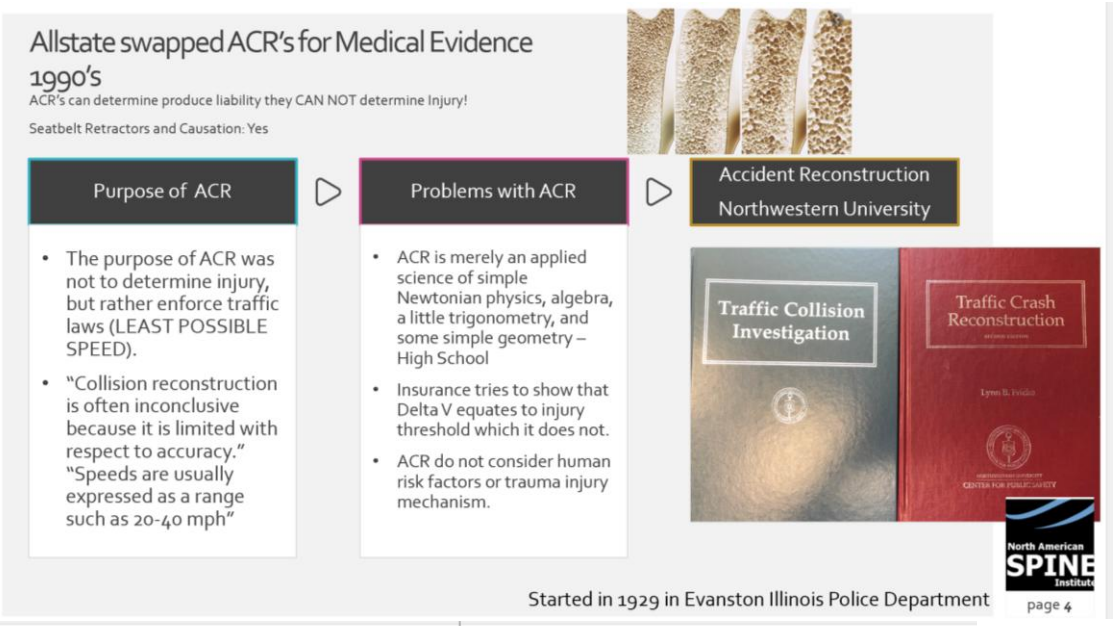
This ideology was found to be untrue but is still used today to adjudicate claims.

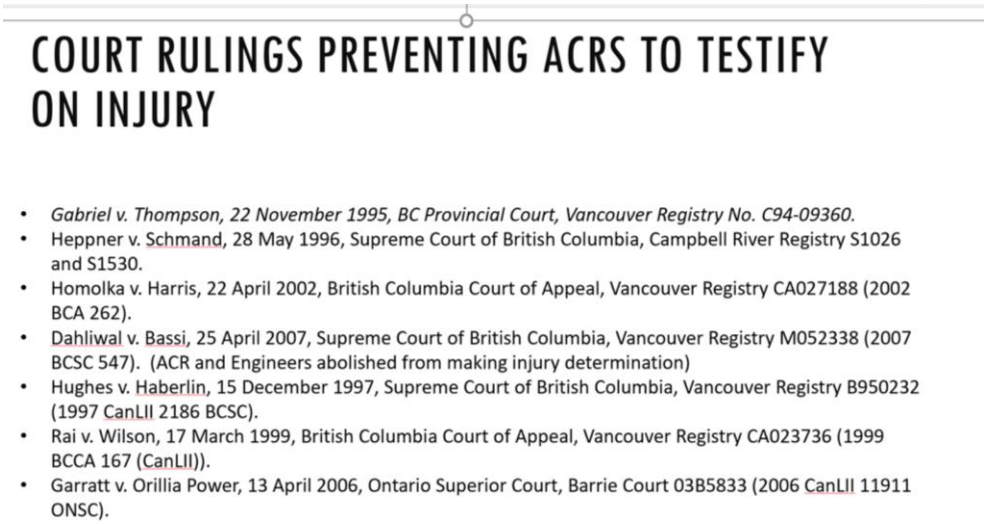
- In order to "prove" this ideology, Allstate instituted the use of defense biomechanist's and defense crash reconstructionist to support their claim that "minor damage" crashes did not injure occupants, even though the data from the US Department of Transportation's National Highway Traffic Safety Administration ("NHTSA") suggested otherwise.
- In low-speed collisions, Accident Reconstructionist and Biomechanist's evaluate injury based on the probability of harm. This idea is used to predict future events and has no logical or meaningful relevance to things that have already occurred. In addition, the usage of Accident Reconstructionist and Biomechanist's to determine injury, in my opinion is Academic Fraud at worst and Intent to Deceive at best based on the science, which I will discuss momentarily.
- Sample Calculation
  - This is a slide from my Post Graduate Continuing Education Seminar: Whiplash Traumatology, Neurophysiology, Pain and Treatment Seminar Series: A Multidisciplinary Approach to Care. The only Post Graduate Continuing Education Seminar in the World Accredited by the Medical, Chiropractic and Physical Therapy community and which is currently accredited in 29 countries.



  - In this example, I compare the difference between two different extents of vehicle damage or the "amount of crush" the vehicle has sustained.
  - In the equation to the left, the amount of damage is 3.1 feet (1 meter) in the right equation, the amount of damage is .66 feet (.2 meters). As you can see, due to the second equation, having less damage/less crush, there is an increase in elastic energy (g force) that acts on the occupant. Accident Reconstructionist and Biomechanist's cannot account for this in their equations as there is "nothing to measure". This elastic recoil has been found to result in significantly higher potentials for injury to occupants. As you can see from the equation above, the lower crush/less damaged vehicle undergoes a much greater g force, 37 g's vs. 7 g's. This is precisely why a race car drivers' car can completely fall apart in a crash and the driver walks away injury free. Because the crush acts as a form of ride down, elongating the time of the collision and thus reduces the g force acting on the occupant.
  - Consider this example. If I took a glass and through it off a brick wall, the pieces would shatter onto the floor. An Accident Reconstructionist, Engineer or Biomechanist's could repeat this process over and over measuring the fragment dispersion pattern until a precise fracture force was calculated for that glass. But if I did this same experiment with a Tennis Ball, there would be no information for an Accident Reconstructionist, Engineer or Biomechanist's to use, and this is what happens in Low-Speed Collisions. Significant force is present that cannot be measured due to the elastic component of the collision.

- A low-speed collision is considered to be a collision with a Delta V (change in velocity) under 10 mph. I have witnessed and been part of research involving Live Full Scale Human Volunteer Crash Testing, in which motor vehicle collisions with occupants in vehicles sustained 18 mph collisions with no visible vehicle damage. In addition, research has shown that occupants of motor vehicle collisions, due to the kinematic response, can sustain 2.5 times higher acceleration forces acting on their spine as compared to the force acting on the vehicle. These factors are NOT considered by Accident Reconstructionist, Engineers or Biomechanist's.



- 

MIST Defense:

- 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, 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.

- These practices are still employed in Ontario today.

Breakdown of Insurance Profits based on Systemic Discrimination:

- 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 83.2 cents 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.

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.

The courts stated MIST worked in three 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. Lastly, they would take a scorched earth approach to claim litigation.

As described above this process 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 in addition to lost income due to this process of Systemic Discrimination by the insurer.

- 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).
- 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 in my opinion for financial gian.

- If as plaintiff lawyers you do not utilize qualified chiropractors you are allowing auto insurers to impose strategic practices, that are designed to limit your clients benefits and treatment need.

- 376 S.W.3d 414 (Ark. 2011), 10-257, Allstate Ins. Co. v. Dodson
- Wal-Mart Stores, Inc. v. Lee, 348 Ark. 707, 738, 74 S.W.3d 634, 655 (2002).

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 injury case, followed by medical specialists, medical doctors, and then finally chiropractors.

This is even in lieu of the fact that medical specialists own professional associations and the Royal College of Physicians and Surgeons stipulate that whiplash injuries are out of scope.

- Ontario Orthopedic Association. Whiplash is "outside of the orthopaedic specialty. It would not be complaint with our Royal College certification to accredited outside of the expertise of our committee."
  - Email correspondence.
- Medical Specialists. Royal College of Physicians and Surgeons. "I am not aware of Whiplash specifically being part of the current national standards."
  - Email correspondence.

This concept of medical hierarchy was one of the founding principles of colossus, in that the system intentionally provided no claim value for treatments provided by Chiropractors and provided greater claim value for treatments provided by medical specialists and surgeons. This was a way to reduce overall claim costs at the insured's expense.

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.

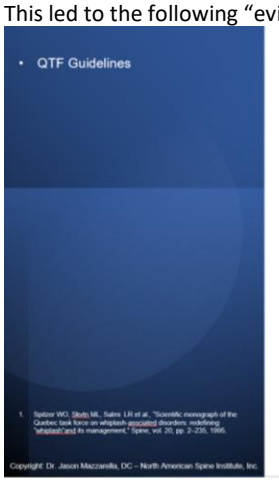
> ***Application of Guidelines***
>
> *"Reasonable and equitable peer review requires serious consideration of a patient's complaints and the physical and laboratory findings, along with a consideration of known risk factors and complicating features. It is scientifically, clinically and ethically unsound to apply any practice guideline without such consideration. The consanguineous*

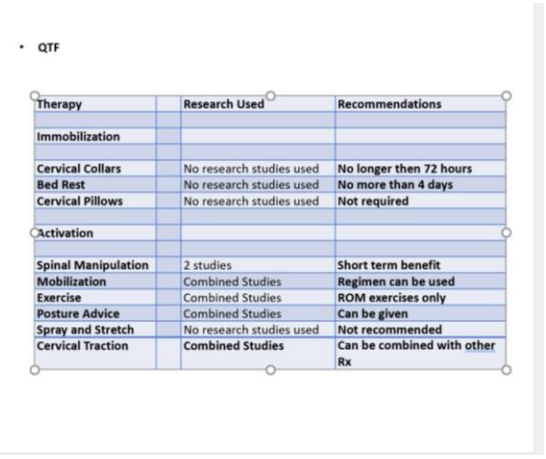
marriage of statistics and guidelines - in the vacuum of clinical information - provides nothing more than an example of a wrong question inviting an irrelevant answer." Arthur Croft

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

<u>The Quebec Task Force Guidelines - Summary:</u>

- 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)."
- "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."
    - Whiplash coined by H.E. Crowe in 1928.
    - H.E. Crowe stated in 1984, "I have regretted the coinage ever since because the coinage proved to be counterfeit …. I never published the term "whiplash injury" but it spread across the country, got into published literature and became a household word which is used thoughtlessly by the layman, the attorney, and the physician."

- "The strategy of the Task Force was to use the "preeminence 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".
    - 



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**

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• 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.
- 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).
    - 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.
    - 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.

<u>Specific comments from the QTF Spine Journal Publication</u>

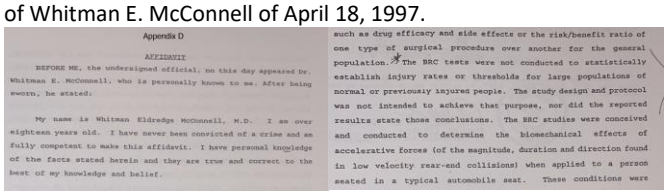
- The Quebec Task Force on Whiplash Associated Disorder reports that the purpose of the development of their whiplash guidelines on page 8S stating, "The province of Quebec; the Task Force reports an extraordinary expense of some $1.5 million (Canadian Dollars) for physiotherapy, when medical expenses were $230,000. Yet the report clearly finds no proven value for physiotherapy."

    - *This shows that the entire purpose of the QTF and now 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."
    - They failed to consider work by Gay and Abbott in 1953 that provided evidence that whiplash resulted in injury to spinal ligaments of the cervical spine.
    - The authors, Gay and Abbott stated, "Stated that they believed that there was damage to the spinal ligaments due to the characteristic symptoms of a muscular sprain/strain.
    - Common Symptoms
    - Memory Impairment
    - Poor Concentration
    - Sleep Disturbances
    - Anxiety
    - Irritability
    - Back stiffness with pain
    - Pain on movement of the spine
    - Headaches
    - Extremity Numbness
    - Arm and hand pain
    - Flushing
    - This resulted in the Davis Theory
    - They stated, "a most distressing psychoneurotic reaction occurred in 52% of the people"
- 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 was in contrast to the research stated above that was used by the task force to determine long term consequences.
    - It was also contradictors to the state that whiplash injuries "residual disability of victims appears significant in magnitude."
- 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 represents 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. <u>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.</u> 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 was 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."

- Please note that this was a misrepresentation of what Dr. McConnell's study said.
- 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 was 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.



Appendix D

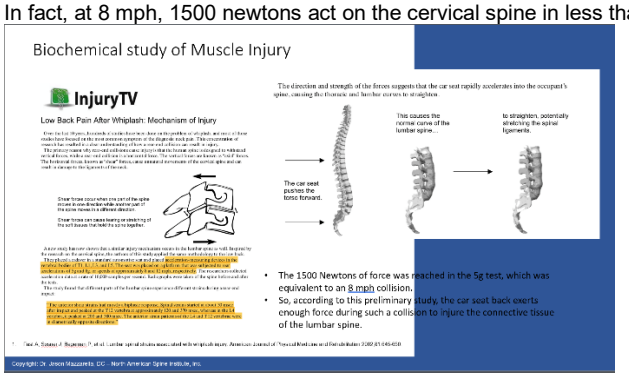
AFFIDAVIT

BEFORE ME, the undersigned official, on this day appeared Dr. Whitman E. McConnell, who is personally known to me. After being sworn, he stated:

My name is Whitman Eldredge McConnell, M.D. I am over eighteen years old. I have never been convicted of a crime and am fully competent to make this affidavit. I have personal knowledge of the facts stated herein and they are true and correct to the best of my knowledge and belief.

such as drug efficacy and side effects or the risk/benefit ratio of one type of surgical procedure over another for the general population. The BRC 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 was not intended to achieve that purpose, nor did the reported results state those conclusions. The BRC studies were conceived and conducted to determine the biomechanical effects of accelerative forces (of the magnitude, duration and direction found in low velocity rear-end collisions) when applied to a person seated in a typical automobile seat. These conditions were

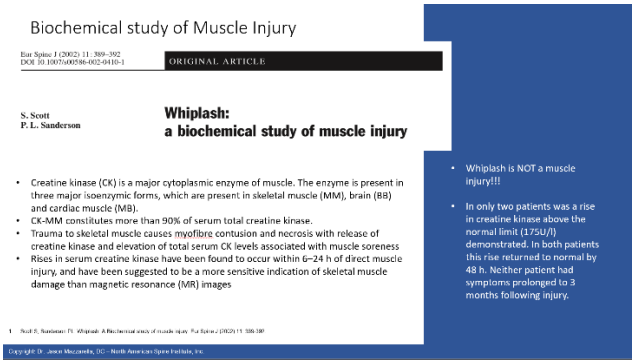
- Therefore, if an Accident Reconstructionist, Engineer or Biomechanics attempts to suggest that there is a force injury threshold, that suggestion a misrepresentation of the literature. There is no definitive research suggesting a minimum force injury threshold for whiplash.
- In fact, at 8 mph, 1500 newtons act on the cervical spine in less than 0.080 seconds.



- THIS IS EQUAL TO A 337 BARBELL FALLING ON ONE MOTION SEGMENT OF YOUR NECK IN LESS THAN 1/10TH OF A SECOND. THINK ABOUT THAT FOR A MOMENT.

Force	Real-World Equivalent	Duration
1500 N	337 lb weight	0.080 s

- 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."
  - Recent Research shows this is inaccurate.



- Please see Whiplash Traumatology mechanism and spinal consequence below.

- 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."
    - Perspective. MRI and CT were not commonly used in Hospital settings until the mid to late 1990's. The research regarding whiplash injury that is used today predated mainstream MRI and CT usage.
- 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"
    - Advances in pain management show this is not longer a factual statement.
- 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**."
- Here is a list of CCE programs. Note. Dr. Jason Mazzarella has the only approved program for CCE and CME.

Instructor	Credentials	Program / Topic	Approx. Period Taught	Accrediting / Sponsoring Organizations
Arthur Croft	DC, MS, MPH, PhD	Whiplash Injury: Biomechanics & Traumatology	1990s–2010s+	Spine Research Institute of San Diego (SRISD), Los Angeles College of Chiropractic, postgraduate CE programs National Univers... +1
Dan Murphy	DC	Whiplash, spinal trauma, impairment and evidence-based spine care	1990s–present	Numerous state chiropractic boards and CE providers (varied by year)
Lawrence Nordhoff	DC	Whiplash traumatology and motor vehicle injury management	1990s–2000s	Various chiropractic CE organizations
Jason Mazzarella	DC, DAAPM, DCAPM, DAAETS, FIAMA, etc.	Whiplash Traumatology & Treatment: Multidisciplinary Approach to Care	2008–present	Medical and chiropractic continuing education programs; programs taught for organizations including the American Chiropractic Association and university-level programs. The 108-hour seminar series was described as accredited for both medical and chiropractic continuing education. European Chiro... +1
Michael Freeman	MD, MPH	Whiplash epidemiology, causation, chronic injury	2000s–present	Medical and legal educational conferences
Harry J. M. von Piekartz	PT	Cervicogenic headache and whiplash rehabilitation	2000s–present	International physiotherapy CE programs
Nikolai Bogduk	MD, PhD	Cervical facet injury, neck pain, whiplash pathology	1990s–present	International medical CME conferences
Michele Sterling	PT, PhD	Whiplash-associated disorders and rehabilitation	2000s–present	International physiotherapy and medical CME conferences

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 auto insurers in Ontario use 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 30 years old.*** This ideology is no longer pertinent to the claims handling process of today and has no place in the Ontario Insurance system.

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 otological 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, auto insurers have designed specific policies and procedures to limit recommendations by Chiropractic Doctors, with the sole intention of claim cost reduction, which is Systemic Discrimination.

- Chiropractic Care: Department of Veterans Affairs Veterans Health Administration Washington, DC 20420, VHA DIRECTIVE 1210, May 25, 2018.
    - "Chiropractors utilize standard medical evaluation procedures, along with biomechanical assessments, to establish a diagnosis and formulate a management plan."
    - "Chiropractic care is included in Joint Commission pain management standards, and evidence shows that patients receiving chiropractic care are: (1) Less likely to use other health care services that are more costly and have greater risk, such as opiate medications, spinal imaging and injections, and elective spinal surgeries; and (2) Have lower overall health care costs for episodes of non-operative spine related disorders."

<u>Insurance's overrides 2015 Guidelines in favour of MIG.</u>
<u>Enabling Recovery from common Traffic injuries: A focus on the Injured Person NAD</u>

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 report a 2-year collaboration and used 43 new studies to make this guideline.
- Of note I was working in Ontario at the time of this guideline publication, and I was asked by Allstate Insurance Company of Canada to review this guideline as their medical expert. I know for a fact that the authors missed the expected guideline for publication several times and there was a great push from insurance stakeholders for this guide to be produced. This could be why only 43 studies were used and only 597 studies were reviewed in total.
- The authors reported on page 6, "Having considered the narratives of persons who experienced injuries and received care under the MIG, *<u>we have concluded that it is NOT appropriate to categorize either the injuries or their associated symptoms as minor injuries</u>*, 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**."
- On page 120, "The guideline does not cover headaches that persist more than six months post collision."

As per the FSCO website, https://www.fsco.gov.on.ca/en/auto/autobulletins/2014/Documents/a-01-14-1.pdf, the following is listed about Minor Injuries.

- Page 4, "The SABS and this Guideline are intended to encourage and promote the broadest use of this Guideline, recognizing that most persons injured in car accidents in Ontario sustain minor injuries for which the goods and services provided under this Guideline are appropriate."
- Page 4, "Definitions: For the purposes of this Guideline:"
    - a) "minor injury means a sprain, strain, whiplash associated disorder, contusion, abrasion, laceration or subluxation and any clinically associated sequelae. This term is to be interpreted to apply where a person sustains any one or more of these injuries."
    - E) "whiplash injury means an injury that occurs to a person's neck following a sudden acceleration-deceleration force.
    - F) "whiplash associated disorder means a whiplash injury that:
        - (i) does not exhibit objective, demonstrable, definable and clinically relevant neurological signs, and
        - (ii) does not exhibit a fracture in or dislocation of the spine

Based on the review of The Quebec Task Force Guidelines and the Ontario FSCO funded guidelines, Enabling Recovery from Common Traffic Injuries: A focus on the Injured Person NAD, proper application of the "Minor Injury Guidelines" would include the following:

- 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." - NAD
- Would only apply to rear and side impact collisions resulting in injury to the neck only – QTF
- On page 82: The NAD Guideline specifically states that it DOES NOT cover pain that "persists for more than 6 months."
- On page 120, "The guideline does not cover headaches that persist more than six months post collision."

What we have learned since the publication of the QTF, 31 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 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 Cervicocephalic Syndrome** (formerly called WAD/Whiplash) comprises the various symptoms that occur as a result of external force such as that of a traffic accident.

- Neck pain or stiffness
- Reduced range of motion in the cervical spine
- Muscle tightness (upper traps, sub-occipitals, SCM)
- Shoulder and upper back pain
- Jaw or TMJ discomfort
- Headaches starting from the neck
- Occipital headaches (back of head pain)
- Temporal or frontal headaches
- Pain behind the eyes
- Head pressure or “tight band” sensation
- Dizziness or light-headedness
- Feeling off-balance or unsteady
- Sensation of rocking or floating
- Difficulty walking straight in visually busy environments
- Visual blurring or fluctuating vision
- Difficulty focusing or reading
- Eye strain
- Trouble tracking moving objects
- Motion sensitivity (cars, screens, scrolling)
- Brain fog
- Poor concentration
- Short-term memory issues
- Mental fatigue
- Slowed thinking or processing
- Fatigue disproportionate to activity
- Sleep disturbances
- Stress intolerance
- Exercise intolerance
- Palpitations or autonomic-type symptoms
- Increased sensitivity to pain (allodynia/hyperalgesia)
- Widespread body pain beyond the neck
- Symptoms worsened by prolonged posture or desk work
- Symptom fluctuation throughout the day
- Reduced tolerance for driving or screen use
- Hormonal changes

Traumatic Cervicocephalic 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 otological 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.*

Why Allopathic Medicine was chosen to outweigh Chiropractic Medicine.

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. Auto insurers in Ontario know this and have 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.

- Ontario Auto Insurers depend on a Medical Doctors review to limit the scope of the assessment to a body part or sub-system, such as the musculoskeletal system to reduce claim exposure. We see this in medical reports when medical doctors limit injury determinations to a specific perspective, such as a surgical perspective, or physical medicine perspective, even though this is not directly requested.
- 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

  Chiropractic is the only regulated health profession listed in the Health Professions Act of 1991, that has a specific scope of practice related to whiplash traumatology injury mechanisms, which is injury to the spine that results in nervous system dysfunction. It is literally in the scope of practice. This is why Ontario auto insurers do their best to limit chiropractic opinion's during the claim process.

Traumatic Cervicocephalic 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 otological 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 Cervicocephalic Syndrome and thus would be the leading experts specifically trained to assess and treat whiplash injuries.**
- Auto insurers in Ontario 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. by minimizing Chiropractic Doctors scope in favour of Medical Doctors.
- 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". By removing the one health profession that specifically is trained to assess structure and functional of the spine, Ontario auto insurers fail in providing equal consideration.
- 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 have chiropractors OCF 18's request evaluated by a peer, another chiropractor in the same profession, in my opinion Ontario claims adjuster fail to meet the standard set by Usanovic v. Penncorp Life Insurance Co.

- 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

Insurance Deceptive Act: Financial Regulator Service Commission Ontario

Unfair or Deceptive Act or Practice

- 2(1) For the purposes of the definition of "unfair or deceptive act or practice" in section 438 of the Act, conduct, including inaction or omission, which results in, or could reasonably be expected to result in the outcomes, events or circumstances set out in s. 3 through s. 10 of this Rule is prescribed as an unfair or deceptive act or practice.
- Any provision of the Act, or a regulation or Authority rule made under the Act, not being complied with resulting in the unfair treatment or unfair discrimination of a person.

Unfair Claims Practices

- 5(1) Unreasonable or unfair resolution or delay in the adjudication, adjustment or settlement of any claim, including but not limited to,
    - (i) *treating a claimant in an arbitrary, capricious* or malicious manner,
        - MIG diagnosis without consideration of trauma.
    - (ii) *not acting in good faith*,
        - Use medical doctor without a scope of practice to comment on a chiropractic treatment plan, different healthcare profession under the regulated health professions act of 1991.
    - (iii) *seeking a result which is inequitable or inconsistent with a claimant's rights under the contract,*
        - The SABs states the insurer must pay for reasonable care, NOT acute care which is what they are doing.
    - *(iv) imposing unreasonable or unfair costs or expenses on the (1) claims handling or dispute resolution processes, (2) goods or (3) services*,
        - The insured in some cases pay more for medical assessments that treatment plan under review are requesting.
    - (v) *communicating in an untimely manner or misrepresenting the rights of a claimant or obligations of an insurer under the contract, or*
        - The insurer reports "Minor Injury", then specifically systemically discriminated against a Chiropractor Doctors by having Medical Doctor that narrow their scope deny benefits.
    - *(vi) any adjuster or insurer not following fair, simple and accessible claims handling procedures or not providing a claimant timely, clear, comprehensive and accurate information about the status of its claim, the process for settling its claim or reasons for a decision made respecting its claim.*
    - Link: https://www.fsrao.ca/media/6116/download

Unfair or Deceptive Acts or Practices, O Reg 7/00

- Section 1.9 of the act which states, "Any conduct resulting in unreasonable delay in, or resistance to, the fair adjustment and settlement of claims." The insurer used a medical professional, with a different scope of practice and from a different profession under the Regulated Health Professionals Act with the sole intent to reduce claim costs based on differences in practice methods.
- Section 5.2 of the act which states, " The determination by an insurer that a person is not entitled to a statutory accident benefit or that a person does not have a catastrophic impairment if,
    - i. the insurer makes the determination before obtaining a report of an examination in respect of the person under section 42 of the Schedule, and
    - ii. the Schedule does not authorize the insurer to make the determination without having obtained the report." The insurer denied the treatment plan based on previous IME findings without first obtaining a new report to evaluate the insured's current needs and status.
- Section 5.4 of the act which states, "A requirement by an insurer that an insured person attend for an examination under section 42 of the Schedule **conducted by a person whom the insurer knows or ought to know is not reasonably qualified by training or experience to conduct the examination**. The insurer used a medical professional in a different area of medicine with a different scope with the sole intention to reduce claim costs at the insureds expense, as per cost analysis information posted above.
    - **Chiropractic Act, 1991 Authorized acts**
    - **4** In the course of engaging in the practice of chiropractic, a member is authorized, subject to the terms, conditions and limitations imposed on his or her certificate of registration, to perform the following:
    - 1. Communicating a diagnosis identifying, as the cause of a person's symptoms,
    - SO 1991, c 21 | Chiropractic Act, 1991 | CanLII
    - Under the Chiropractic act, a chiropractor is legally allowed to perform the following acts: "Communicating a diagnosis identifying, as the cause of a person's symptoms a disorder arising from the **structures or functions of the spine and their effects on the nervous system."** This again, is by definition, what Whiplash

is and what Chronic Pain is related to a motor vehicle accident, a spinal biomechanical change that results in nervous system functional loss.

- 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. 1991, c. 18, s. 33 (2).
  - SO 1991, c 18 | Regulated Health Professions Act, 1991 | CanLII
- Under the Regulated Health Professions Act of 1991, there is no differentiation or indication of superiority between professions allowed to use the term doctor. There is not suggestion or implication that one profession is superior to another. The idea of superiority as noted above was introduced by Allstate Insurance Company in 1994 through the Colossus Computer Program for the sole purpose to reduce claim costs as previously discussed.

1. Unfair or Deceptive Acts or Practices, O Reg 7/00: O Reg 7/00 | Unfair or Deceptive Acts or Practices | CanLII

Based on the above information, it is my opinion that enforcing the Minor Injury Guideline to a patient that has sustained injuries to other regions of the body outside of soft tissue, and whose pain has persisted for more than 6 months, to be an *Unfair or Deceptive Act or Practice as per the Financial Service Regulator Authority of Ontario and an Unfair or Deceptive Acts of Practices*, as any person can see a deliberate misinterpretation of the literature for financial gain by the insurer. This specific and deliberate action to deny warranted benefits by misquoting the literature that the Minor Injury Guideline was based on then has resulted in prevention of patient's basic human right to pain management and Chiropractors Canadian Charter of Rights to gainful employment.

- "The concept of access to pain management as a human right has gained increasing currency in recent years. Commencing as individual advocacy, it was later embraced by the disciplines of pain medicine and palliative care and by mainstream human rights organizations."
- "Today, United Nations and regional human rights bodies have accepted the concept and incorporated it into key human rights reports, reviews, and standard."
- "Despite the prevalence of pain and its impact on quality of life, undertreatment remains a major problem. There are many barriers to pain management: inadequate access to health facilities, lack of training of health professionals, lack of acknowledgment of pain."
- "The American Medical Association states that "Physicians have an obligation to relieve pain and suffering," and the World Health Assembly resolved that "It is an ethical duty of health care professionals to alleviate pain and suffering." In response to the major gaps in treatment, pain and palliative care professional associations went further and made a series of declarations asserting that pain management and palliative care are basic human rights."

    - Brennan F, Lohman D, Gwyther L. Access to Pain Management as a Human Right. Am J Public Health. 2019;109(1):61-65. doi:10.2105/AJPH.2018.304743

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 I have described above, there was a calculated and deceptive tactic employed by the insurer based on previous knowledge of cost containment strategies first developed in the United States, and later which were deemed to be considered systemic bad faith, that were utilized in the handling of this claim, which in my opinion violates both my Ontario Human Rights and my Canadian Charter of Rights to fair gainful employment.

As part of this Good Faith claims process, the Canadian Chart of Rights and the Ontario Human Rights Code, during adjudication of a claim the insurer must not employ deceptive tactics that are discriminatory in nature for the sole purpose of claim cost reduction. However, typically insurers do just this by systemically discriminating against the chiropractic profession in order to reduce claim costs which I have detailed in this document, and which have been deemed deceptive tactics in United States Supreme Courts.

In addition, when insurers deny treatment plans based on "MIG" as an explanation or rational for denial, in my opinion, as per King Day Holdings Ltd. v. The Owners, Strata Plan LMS3851 is bad faith. King Day Holdings Ltd. applies in which the court stated, this "appears to reflect not a studied review of the evidence, but instead a grab-bag of whatever considerations could identify to justify a denial of coverage." Which then further supports my concern of bad faith claims handling.

- King Day Holdings Ltd. v. The Owners, Strata Plan LMS3851, 2020 BCCA 342 (CanLII)

Review of Ontario Human Rights Commission

- **Considerations for Systemic Discrimination**
- **Considerations for Violation of Basic Human Right to Pain Management**
- **Consideration for handling of conflicting Medical Recommendations.**

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**.

Additional Statements regarding Systemic Discrimination

1. Systemic discrimination occurs when structural barriers or widespread stereotypes and assumptions bar certain groups of people from full participation in activities covered by The Saskatchewan Human Rights Code
    a. The widespread stereotypes falsely imprinted into society by insurance carrier devalues and minimizing Chiropractic Doctors scope and training, in direct conflict with the Regulated Health Professionals Act.
2. Systemic discrimination may occur where long term practices have resulted in structures of work that disadvantage individuals because they are members of certain groups
    a. Members of the College of Chiropractors of Ontario are unjustly disadvantaged due to a fictious medical hierarchy developed by auto insurers to reduce claim costs, in direct conflict with the Regulated Health Professionals Act.
3. Systemic discrimination also includes policies and practices that are seemingly neutral but may cause a disparate impact on protected group
    a. The insurance carrier devalues and minimizes Chiropractic Doctors scope of practice and training by suggesting a medical hierarchy exists which does not. The usage of a medical doctor to adjudicate a chiropractic treatment plan gives the appearance of neutrality, however, as I have shown, there is specific intent based on predetermined risk containment models showing that medical doctors minimize their scope of assessment, resulting in overall claim cost reduction to insurers.

- https://www.lawinsider.com/dictionary/systemic-discrimination

As noted above the usage of a Medical Specialist to deny a Chiropractic Treatment and Assessment Plan is a policy and practice initiated in the 1990's by Allstate Insurance Company for the sole purpose of claim cost reduction, and which was used in this case to deny a warranted and necessary treatment plan.

Insurance Industry and Pain Management.

Initially enthusiastic about Interdisciplinary Pain Management. The insurance industry soon considered Physical Medicine Therapy "too expensive" and "not proven". (Loeser) The insurance industry made a conscious decision to ignore evidence-based findings of Interdisciplinary Pain Clinics and this was then followed by the Hospital Systems, stating that Interdisciplinary Pain Clinics will never be a "cash cow" due to labor intensity. (Schatman)

Hospitals tend to terminate services that are not profitable. (Schatman, Lezzoni) For larger American Hospitals, especially associated with a medical school, revenue generation is the major determinant of what services the institution will offer. Interdisciplinary Pain Clinics are not seen as a value compared to cosmetic surgier." (Loeser) Soon after, Insurance Carriers arbitrarily began to not pain for Interdisciplinary Pain Clinics based on their "policies" (Schatman)

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

Medical Doctors were taught in school to distrust chiropractors as a financial motive to control the health sector, which allows for the potential of bias, weather conscious or not.

Wilk v. American Medical Association.

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 believed 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.

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

"During the 1800s, there were a variety of medical sections 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."

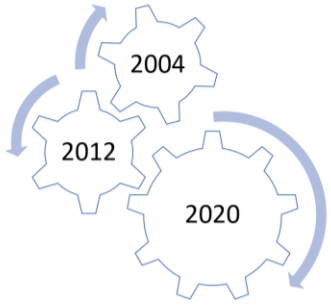
- Supporting documentation: Slides from the Medical, Chiropractic, Physical Therapy and Massage Therapy Accredited Continuing Education program, Whiplash Traumatology, Neurophysiology, Pain and Treatment Seminar Series: A Multidisciplinary Approach to Care
- 

- In a publication in 2020, entitled The Illusion of Evidence-Based Medicine: Exposing the crisis of credibility in clinical research. The authors note that Academics will lend their names to ghost-written papers paid for by drug companies. The companies will then pressure journals to publish the papers; and on the basis of these publications the regulators will then approve the drugs. Because the industry controls every aspect of this process, and the all-important data this has been referred to as organized crime

The Illusion of Evidence-Based Medicine: Exposing the crisis of credibility in clinical research *Jon Jureidini & Leemon B. McHenry* Wakefield (2020)

- This is not NEW material.
- Similar exposés have been produced by mainstream publishers; these including:
- *The Truth About the Drug Companies* (2004) by Marcia Angell, former editor-in-chief of *The New England Journal of Medicine*
- *Bad Pharma* (2012) by the crusading clinical epidemiologist Ben Goldacre.

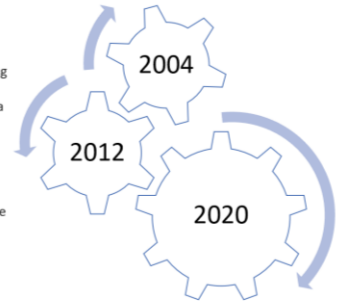
- Little has changed since these works were published, say Jureidini and McHenry. Academics still lend their names to ghost-written papers paid for by drug companies. The companies still pressure journals to publish the papers; on the basis of these, regulators approve drugs.
- Because the industry controls every aspect of this process — and the all-important data — the pair refer to it as "organized crime", following Peter Gøtzsche's 2013 book *Deadly Medicines and Organised Crime*.



- The Illusion of Evidence-Based Medicine: Exposing the crisis of credibility in clinical research Jon Jureidini & Leemon B. McHenry Wakefield Nature 583, 26-28 (2020)

The Illusion of Evidence-Based Medicine: Exposing the crisis of credibility in clinical research *Jon Jureidini & Leemon B. McHenry* Wakefield (2020)

- The authors agree that the randomized, placebo-controlled trial is the best method we have for testing drugs, and they argue that every scientific theory should be tested by, in Popper's phrase, attempting to falsify the null hypothesis. In a trial, this means trying to disprove the idea that the treatment makes no difference. Adhering to this principle, researchers can never say for sure that a treatment is effective, but they can say definitively that it is not effective.
- The authors charge that drug companies have made even that impossible, by designing protocols that guarantee a positive outcome or by spinning a negative one. One concern is the redefinition of endpoints mid-trial — a worry that resurfaced in the context of the US National Institute of Allergy and Infectious Diseases' ongoing trial of the potential COVID-19 drug remdesivir

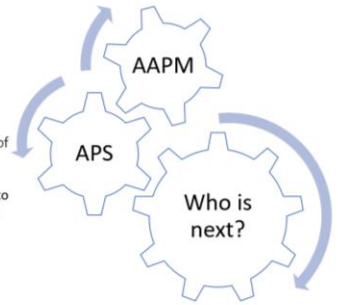


- The Illusion of Evidence-Based Medicine: Exposing the crisis of credibility in clinical research Jon Jureidini & Leemon B. McHenry Wakefield Nature 583, 26-28 (2020)

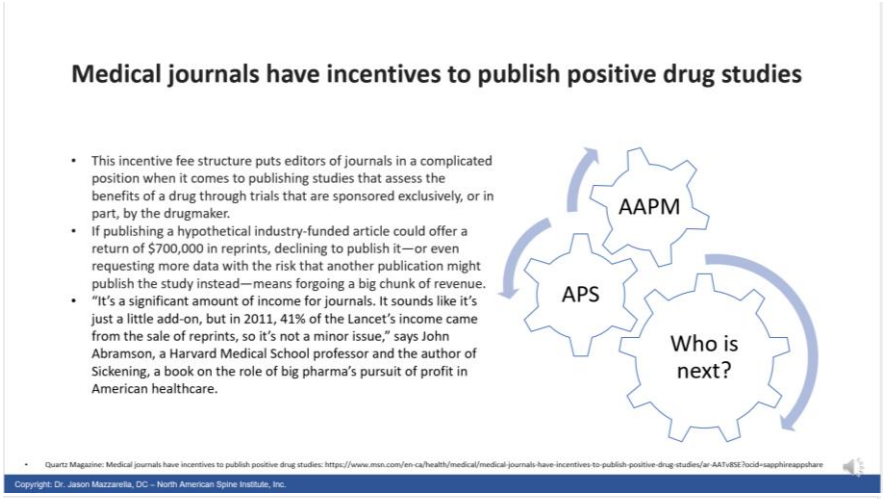
Medical journals have incentives to publish positive drug studies

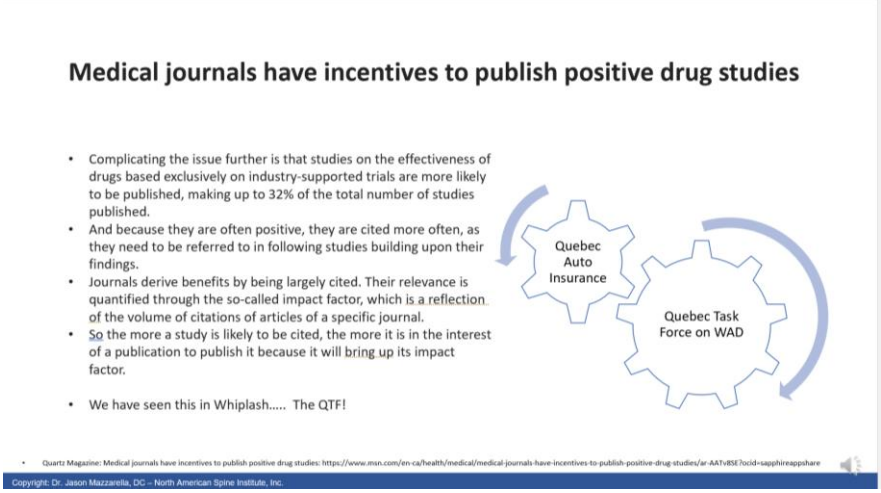
- There is one conflict of interest medical journals often don't disclose—their own.
- Journals often won't give information on their streams of revenue
  - We have seen this with the Opioid crisis with the AAPM and the APS both closing their doors due to lack of funding.

- Study Reprints: This is an indirect way in which journals are incentivized to publish studies that show the positive impact of drugs.
- While journals are academic in nature, they are still a business.
  - The sales of copies of a study might not seem like a gateway to riches, but the reprint purchases can add up to more than $2 million each.
  - That is significant revenue, especially for large journals.
  - The Lancet's revenue total annual is estimated to be about $40 million a year, while NEJM generates around $100 million—of which about a third is profit



- Quartz Magazine: Medical journals have incentives to publish positive drug studies: https://www.msn.com/en-ca/health/medical/medical-journals-have-incentives-to-publish-positive-drug-studies/ar-AATv8SE?ocid=sapphireappshare

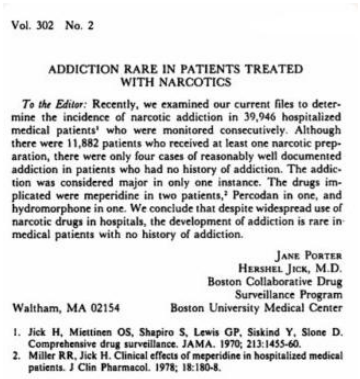
- 

- 

- This understanding of "evidence-based research" shows how medical doctors will be conditioned to minimize physical medicine treatments, as most if not all of the research that they are exposed to is geared towards pharmaceutical interventions only. This lays down a foundation of potential bias that the insurers rely upon and provides further evidence of why they have implemented specific policies and procedures to Systemically Discriminate against Chiropractic.
- When you visit your doctor, you might assume that the treatment they prescribe has solid evidence to back it up. But you'd be wrong. Only one in ten medical treatments are supported by high-quality evidence, our latest research shows.
- 

- The analysis, which is published in the Journal of Clinical Epidemiology, included 154 Cochrane systematic reviews published between 2015 and 2019. Only 15 (9.9 percent) had high-quality evidence according to the gold-standard method for determining whether they provide high or low-quality evidence, called GRADE (grading of recommendations, assessment, development and evaluation).

- And remember when you here the false statement that Chiropractic is unscientific. This is the depth of research that was used to start the opioid epidemic that medicine accepted as evidence based.
- **Jick H, Porter J. "Addiction rare in patients treated with narcotics."** ***New England Journal of Medicine*****. 1980;302:123.**



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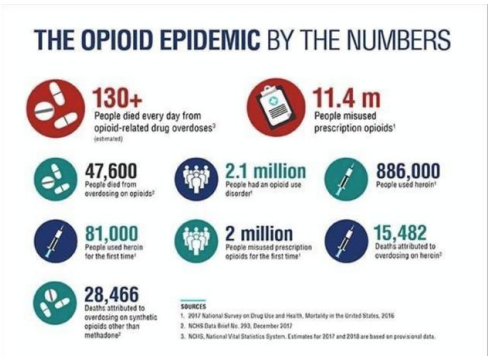
ADDICTION RARE IN PATIENTS TREATED WITH NARCOTICS

To the Editor: Recently, we examined our current files to determine the incidence of narcotic addiction in 39,946 hospitalized medical patients[1] who were monitored consecutively. Although there were 11,882 patients who received at least one narcotic preparation, there were only four cases of reasonably well documented addiction in patients who had no history of addiction. The addiction was considered major in only one instance. The drugs implicated were meperidine in two patients,[2] Percodan in one, and hydromorphone in one. We conclude that despite widespread use of narcotic drugs in hospitals, the development of addiction is rare in medical patients with no history of addiction.

JANE PORTER
HERSHEL JICK, M.D.
Boston Collaborative Drug Surveillance Program
Waltham, MA 02154 Boston University Medical Center

1. Jick H, Miettinen OS, Shapiro S, Lewis GP, Siskind V, Slone D. Comprehensive drug surveillance. JAMA. 1970; 213:1455-60.
2. Miller RR, Jick H. Clinical effects of meperidine in hospitalized medical patients. J Clin Pharmacol. 1978; 18:180-8.



- THIS IS IT. THAT IS THE INDEPTH RESEARCH THAT STARTED AN EPIDEMIC.

"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."

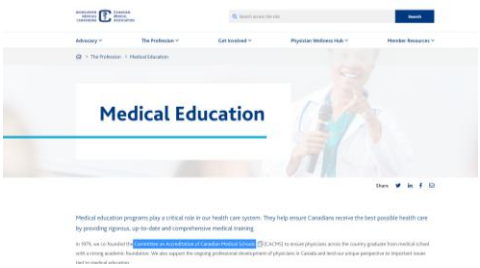
"AMA writers ghostwrote television and movie scripts, as well as Ann Landers' widely read newspaper column and any other media outlet that could be used to tarnish the reputation of chiropractic in the public eye. The AMA even encouraged the distribution of anti-chiropractic materials to high school 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"**

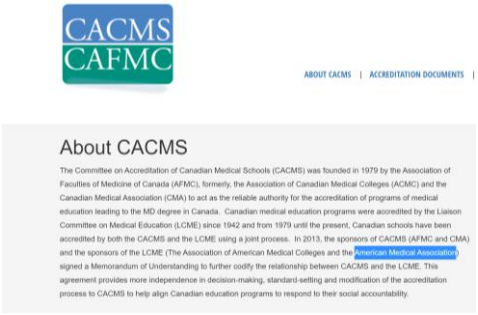
Agocs S: Chiropractic's Fight for Survival. AMA Journal of Ethics. Illuminating the Art of Medicine. 2011;13(6):384-388

Getzendanner S. Permanent injunction order against AMA. JAMA. 1988;259(1):81-82.

Please note the AMA provides part of the accreditation to all Medical Doctors in Ontario



https://www.cma.ca/medical-education



https://cacms-cafmc.ca/about-cacms

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.

We see this in daily claims denials with statement such as, "There is no evidence that the claimant sustained anything other than soft tissue injuries as a result of the motor vehicle accident." "Soft tissue pain is, by default, an entity of most of the other structures in the body besides bone. This includes muscle, fascia, tendons, ligaments, cartilage, synovium, fibrous capsules,

organs, and nerves. Soft tissue pain is often overlooked because it is not as easy to diagnose as pain involving bony structures. However, soft tissue pain can be just as debilitating as pain from bony structures" which an Orthopedic Surgeon would then attend to and treat.

- Wright B. Management of chronic soft tissue pain. Top Companion Anim Med. 2010 Feb;25(1):26-31.

Again, I believe this shows that there is a potential for bias towards Chiropractors by Medical Doctors, and this potential bias is relied upon by the insurer and specifically detailed in their policy and procedures to reduce the risk of overall claim costs. Even a top tier medical doctor can show bias (intentional or not) through their lack of understanding/knowledge of Chiropractic and further supports why a Chiropractic Treatment plan should always be reviewed by a Chiropractic Doctor with the same scope, expertise, and training to ensure fair claim handling processes to the insured and the insurer.

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.*
    a. *This depceptive act of intentionally limiting the scope of Independent Medical Assessments by Systemically Discriminating against Chiropractic and can be seen when physicians comment on therpay need based on findings of a limited scope, orthopedic, physical medicine, neurological, etc and does not consider pain related impairments or the totality of injuires listed on the OCF 18 Treatment and Assessment Plan.*

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.

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.

This is why Whiplash Traumatology injuries are no longer called “soft tissue injuries” in the medical community, but rather Traumatic Cervicocephalic 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 Chiropractor’s 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.

<u>Systemic Discrimination of Chiropractic Hurts us All</u>

- 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-by-province/#:~: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 such as Intact have reported Premium growth of 12% in the quarter and 9% for the full year led by rate increases (quarter 2019)
    - 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.
    - https://www.newswire.ca/news-releases/intact-financial-corporation-reports-q4-2019-results-813973343.html
- Systemic Discrimination of Chiropractic hurts us ALL!

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 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". We see when medical doctors limit scope and only comment from a "specialists perspective."

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 the insurers letter retaining the IME provider the letter was written by an adjuster without whiplash 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 showing the long term consequences of chronic pain. 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 one that is required, that the Independent Medical Examination (IME) the insurer arranged to wrongfully terminate benefits is bad faith. I believe this further solidifies the idea of systemic discrimination against the Chiropractic profession for the sole purpose of financial gain which then violates Chiropractor's Canadian Charter of Rights to gainful employment in Ontario.

If the insurer disagrees with my complaint of Systemic Discrimination against Chiropractic, as pointed out by Alphonse A. DeMaria, D.C., et al., v. Horizon Healthcare Services, Inc. d/b/a Horizon Blue Cross Blue Shield of New Jersey, et. al., No. 11-cv-7298 (WJM)(MF), claims data will accurately reflect the records of the insurers corporate policies. Simple review of claims submitted by Chiropractors between 2015 and present, those approved and denied can be used to determine if Systemic Discrimination exists. By looking both at the percept of claims approved vs denied by Chiropractic Doctors vs Medical Doctors,

Psychological Doctors or Dental Doctors we can determine if a policy and practice is in place to Systemically Discriminate against Chiropractic. Further, by looking at the initially denied claims of Medical Doctors, Chiropractic Doctors, Dentist and Psychologist, we can see the insurers policies regarding if the same profession performs assessments vs different professions for Medical Doctors, Chiropractic Doctors, Dentists and Psychologist.

Final Thoughts:

Given the complexity of traumatic cervicocephalic injuries (commonly referred to as whiplash), legal counsel should consider requesting a sworn Form 53, affidavit, or equivalent declaration from any Independent Examiner prior to allowing a client to attend an insurer-arranged assessment. Such a declaration should confirm the examiner's specific education, training, clinical experience, and expertise in both chiropractic medicine and whiplash traumatology. This is particularly important where the examiner is being asked to comment on chiropractic treatment recommendations, chronic pain, functional impairment, or post-traumatic rehabilitation.

The concern is not merely academic. Research from Harvard Medical School and other institutions have demonstrated that patient beliefs, expectations, and the information communicated by healthcare providers can directly influence pain processing networks within the brain, affecting symptom severity, disability, recovery expectations, and treatment outcomes.

Research:

In understanding chronic pain, we must understand that chronic pain is complex, considered a separate and distinct disease process that develops from a past injury or experience, and that each person will experience pain differently. fMRI testing has shown that even the perception of pain increases the person's subjective response/opinion of their pain.

- The example below by Sawamoto describes a person's response to heat stimulus. When the person was informed the heat would be hot, their pain response increased. When the person was informed the heat would be warm, their response decreased. When the person was informed the response would be hot, but was actually warm, the response to pain was greater than the initial warm response.

We must further understand that Neurobiological research and fMRI studies over the last 20 years has shown that pain left untreated has been shown to re-organize our neurological system, resulting in continued and progressive functional changes to our nervous system and continued harm due to changes in gray/white matter levels, and increased sensitivity to spinal nerves (spinal wind-up).

Research on pain perception, including studies like Sawamoto's, shows that pain is strongly influenced by expectation and cognitive context, not just tissue input. When individuals are told a stimulus will be more painful, their perceived pain increases, and when it is framed as less threatening, pain decreases due to activation of brain networks involved in prediction, attention, and descending inhibition.

In an IME context, if a patient's pain is downplayed or invalidated, this can act as a nocebo effect by increasing threat perception, uncertainty, and emotional stress, which may amplify pain processing in brain regions such as the insula, anterior cingulate cortex, and amygdala. This can also reduce endogenous pain inhibitory pathways, leading to greater perceived pain even without any change in physical injury. When benefits, impairment, or functional capacity are being assessed in an IME setting, it is important that the evaluating doctor has specific training, education, and clinical experience in the relevant injury domain, because pain perception and disability are not determined solely by structural findings but are also influenced by neurophysiological and cognitive factors such as expectation, context,

and communication effects. Without appropriate specialty knowledge, for example, in whiplash-associated disorders or chronic pain mechanisms, there is a greater risk that symptom interpretation will be overly reductionist or dismissive of centrally mediated pain processes, potentially triggering nocebo effects that amplify symptoms and distort functional presentation. A properly trained examiner is more likely to integrate biomechanical injury mechanisms with modern pain science, reducing misclassification of symptoms and ensuring that benefit determinations reflect both objective findings and the established neurophysiological realities of pain modulation.

If these concerns are not appropriately addressed in good faith, we intend to complete standardized pre- and post-IME outcome measures, including the Beck Anxiety Inventory, Beck Depression Inventory, and Pain Catastrophizing Scale, to objectively evaluate any change in the patient's psychological and pain-related status surrounding the assessment process. Any clinically significant deterioration identified through these validated tools will be documented and considered in the broader context of the patient's overall management and claims trajectory, as part of a comprehensive record of functional and psychological outcomes.

Where inaccurate, incomplete, or profession-specific bias influences an assessment, there is a risk that injured individuals may internalize the message that their ongoing symptoms are insignificant, psychological, exaggerated, or their own fault, potentially worsening pain-related disability through well-documented neurobiological mechanisms. Given the historical findings in the Wilk v. American Medical Association litigation, which concluded that the AMA had engaged in unlawful conduct directed at the chiropractic profession, and given that many insurer-funded examinations continue to involve physicians evaluating treatment approaches outside their own clinical scope of practice, it is reasonable for counsel to seek objective confirmation that any examiner possesses relevant expertise and can provide an opinion free from professional bias, ensuring that the assessment process remains fair, balanced, and in the best interests of the injured client.