Editorial
Rosario G. Cartagena ............................................. 161

Considering Tort Liability for Breaches to Privacy of Patient Data—Managing Risks of Applicability of Privacy Torts, and Especially the Tort of “Intrusion on Seclusion” in the Health Context
Rebecca Bromwich ............................................... 162

The Ethical and Legal Dilemma in Terminating the Physician-Patient Relationship
Dr. Helen Senderovitch ........................................ 168

Dr. J. Douglas Salmon, Jr., Dr. Jacques J. Gouws & Corina Anghel Bachmann .... 174

Current Events
Anna Okorokov .................................................. 190

Editorial
Welcome readers to our May edition. Spring is in the air and it is time for change — and that includes Health Care Reform.

In Ontario, the provincial government seems to share a similar appetite for Health Care Reform. Health Minister Eric Hoskins and a team of senior bureaucrats are preparing to unveil a massive reform of Ontario’s health-care system that will impact the lives of every single resident. Central to the reform is a re-organization of the home-care system. As has already been noted in the media, Minister Hoskins is proposing to overhaul the 14 Community Care and Access Centres (CCACs) and move them under the province’s 14 Local Health Integration Networks (LHINs). The goal, as stated by the Ministry of Health and Long-Term Care is to improve patient care from admittance at hospitals, to the services required at home or in their community. It is expected that the health care reform proposal will be tabled in the legislature in May.

At the federal level, similar conversations about health care reform are brewing. Health Minister Jane Philpott has stated that she would like a new Health Accord in place by 2017. The new Health Accord (to be negotiated between the provinces and the federal government) will likely include new long-term funding and set national standards for health care. The 2004 Health Accord expired in
2014 and was not renegotiated by the last federal government. It is postulated that the new negotiated Health Accord will include improvements for home-care access, reducing the costs of pharmaceuticals and providing more access for mental health services.

With both levels of government advocating for change and in light of the 50th anniversary of the introduction of the Medical Care Act, Health Law in Canada is proposing to hold a conference in the Fall on Health Care Reform. The goal of the conference will be to provide a forum for innovative ideas on health care reform to be presented, debated, discussed and ultimately considered by law and policymakers so that positive change with evidence-based data are embraced.

As Minister Philpott said recently in an interview, “Canadians love their health-care system. We’re very proud of it, it’s served us well for half a century now, we’re proud of Medicare, and the fact that Canadians can have access to health care on the basis of need and not on the basis of their ability to pay. But the system was designed in an era where health care was primarily delivered in hospitals, and a number of things have changed”. A few facts are certain, our elderly population is outnumbering the number of taxpayers, wait times for all types of treatments are still lagging in comparison to other OECD countries (for example, minor surgical procedures) and we still pay a lot for pharmaceutical drugs. We, as Canadians, have been discussing health care reform for many years now, let’s get together, set some concrete ideas and move forward towards an innovative and transformative health care agenda.

Rosario G. Cartagena, BSc, MSc, JD
Deputy Editor-in-Chief, Health Law in Canada
Associate, Fasken Martineau DuMoulin LLP
Adjunct Lecturer, Institute of Health Policy, Management and Evaluation

Considering Tort Liability for Breaches to Privacy of Patient Data—Managing Risks of Applicability of Privacy Torts, and Especially the Tort of “Intrusion on Seclusion” in the Health Context

Rebecca Bromwich

Abstract

The mobile revolution is a watershed event across many fields, including health care. Now, electronic data storage, digital photography, smart phones and tablet devices present new opportunities for educators, researchers, and health care providers. Mobile technologies allow for new possibilities for physician collaboration as well as patient diagnosis, treatment and study. However, while it presents new opportunities, the mobile technological revolution in health care has brought about new risks to patient privacy. These risks to patients, in turn, translate into exposure to liability on the part of health care providers including physicians, allied health care professionals and institutions. This paper reviews recent developments in the legal landscape providing new forms of civil liability for breaches of privacy and discusses how risks of liability under those developing civil causes of action can be managed by health care providers, while they at the same time harness the potential of the mobile technological tide.
Introduction

The advent of electronic data storage, digital photography, smart phones and tablet devices has presented a boon to educators, researchers, and health care providers alike. Patients can be diagnosed, treated and studied in exciting new ways and patient images can be shared for the purposes of clinical care faster than ever before. However, at the same time that it presents new opportunities, this technological revolution in health care has brought about new risks to patient privacy. These risks to patients, in turn, translate into possibilities of liability on the part of health care providers including physicians, allied health care professionals and institutions. Recent developments in the legal landscape provided new forms of civil liability for breaches of privacy that can give rise to court orders or settlements in the millions of dollars. However, the good news is that it’s easy and inexpensive to guard against them.

In certain provinces, including Alberta, British Columbia, and Newfoundland and Labrador, provincial privacy laws have set out statutory causes of action for breaches of privacy. In Ontario, the situation is somewhat divergent. Ontario’s Personal Health Information Protection Act, 2004 [PHIPA] does set out a statutory cause of action for health-related privacy breaches (at s. 65). However, as discussed below, in Hopkins v. Kay, the court has found that this statutory privacy protection was not the sole or exclusive basis on which claims for breach of privacy can proceed and allowed the intrusion on seclusion claim where the common law tort of “intrusion on seclusion” has relatively recently been established to address the situation where privacy breaches “cry out for a remedy” (Jones v. Tsige, at para. 69). Also in Ontario, a new tort of “public disclosure of private facts” has further moved the bar on privacy torts, opening up possibilities for still more civil actions in relation to privacy breaches.

The Tort of “Intrusion on Seclusion”

In Jones v. Tsige, the Ontario Court of Appeal extended protections of privacy available under the law by ushering into existence the new tort (civil cause of action) of “intrusion on seclusion”. A legal framework for breaches of healthcare privacy already existed in several provinces in the form of privacy statutes enforced by the federal and provincial privacy commissioners. What the Jones v. Tsige case adds is a general, broadly-framed, common law cause of action outside of privacy law (in Jones v. Tsige, the legislation at issue was the Personal Information Protection and Electronic Documents Act [PIPEDA]) at least in some jurisdictions. This creates an increased exposure to liability. Civil damages for “intrusion on seclusion” that could be ordered against health care providers are potentially in the millions of dollars.

As is typical of tort law, where common law principles about civil wrongs are applied in nuanced ways to individual cases, the Jones v. Tsige decision turned narrowly on its particular facts. In Jones v. Tsige, a defendant bank employee, Winnie Tsige, used her work computer to improperly access the plaintiff bank employee, Sandra Jones’ electronic banking records. The defendant did not make any changes to the records but she spied on them intensively and persistently for several years. She viewed them on over 200 occasions over a four-year period. The Court of Appeal found Tsige’s behaviour egregious, characterizing it at para. 69 of the decision as “deliberate, prolonged and shocking”. While the parties were both employees of the same institution (albeit at different branches), they did not know each other. What drove Tsige’s curiosity was her romantic relationship with Jones’ former husband.

In Jones v. Tsige, Sharpe J., writing for a unanimous panel of the Ontario Court of Appeal, opted to introduce a new Canadian cause of action in tort for “intrusion on seclusion”, adapting this from
well-established U.S. privacy torts, as well as precedent from the U.K., Australia and other common law jurisdictions. The court reasoned that the “Charter value” of privacy should inform the interpretation of the common law, and that federal and provincial privacy legislation does not foreclose the establishment of such a civil cause of action. Of perhaps the significance to the context of electronic medical records was the further reasoning in the judgment that technological advance has brought about a need for new and better protections on privacy. On this point, the court held (at paras. 67 – 69):

[67]  For over one hundred years, technological change has motivated the legal protection of the individual’s right to privacy. In modern times, the pace of technological change has accelerated exponentially. Legal scholars such as Peter Burns have written [p. 261] of “the pressing need to preserve ‘privacy’ which is being threatened by science and technology to the point of surrender”: “The Law and Privacy: the Canadian Experience”, at p. 1. See, also, Alan Westin, Privacy and Freedom (New York: Atheneum, 1967). The internet and digital technology have brought an enormous change in the way we communicate and in our capacity to capture, store and retrieve information. As the facts of this case indicate, routinely kept electronic databases render our most personal financial information vulnerable. Sensitive information as to our health is similarly available, as are records of the books we have borrowed or bought, the movies we have rented or downloaded, where we have shopped, where we have travelled and the nature of our communications by cell phone, e-mail or text message.

[68]  It is within the capacity of the common law to evolve to respond to the problem posed by the routine collection and aggregation of highly personal information that is readily accessible in electronic form. Technological change poses a novel threat to a right of privacy that has been protected for hundreds of years by the common law under various guises and that, since 1982 and the Charter, has been recognized as a right that is integral to our social and political order.

[69]  Finally, and most importantly, we are presented in this case with facts that cry out for a remedy…

While the Jones v. Tsige case emerges from particular, narrow factual circumstances and is only binding precedent in the province of Ontario, it has been adopted in some other provinces, such as Newfoundland and Labrador, and privacy-related class actions are burgeoning. Further, the case has implications for other contexts in addition to that of banking records, especially in other situations where the “routine collection and aggregation of highly personal information… is readily accessible in electronic form” (ibid.). Because electronic medical records, rife with deeply personal data and images, are now proliferating and are precisely the sort of highly personal information to which a privacy interest can attach, it is not surprising that, as is discussed below, the tort of intrusion on seclusion has recently been applied in the health care context.

In Hynes v. Western Regional Integrated Health Authority, the Supreme Court of Newfoundland and Labrador certified a class action brought by 1,043 individual patients whose personal health records had been accessed by an employee of the Defendant hospital. Records accessed included demographic information (patients’ address, age, religion), the names of patients’ next of kin, the name of their emergency contact person, information about the patients’ visits to the hospital, reasons for the visit, and records of what diagnostic or surgical procedures occurred during hospital visits.

The certification of a class action is a court’s determination that the suit can proceed through the court process. It does not finally conclude the question of liability. No determination has yet been made as to why the employee accessed the records in question and there has been no allegation that anything improper was done with the information. Nonetheless, the hospital now faces the costly, time-intensive spectre of defending a class action lawsuit. Class actions often result in settlements or judgments in the millions of dollars. What the Hynes case will ultimately cost the Defendant Health Authority remains to be seen.
Similarly, in an Ontario case, Hopkins v. Kay, the Ontario Superior Court, on a Rule 21 motion, declined to dismiss a case for intrusion on seclusion against a hospital. Rule 21 is a procedural directive that permits courts to summarily dismiss claims by striking pleadings for failing to disclose a cause of action where it is “plain and obvious” that there is no genuine issue for trial, as was made clear in MacDonald v. Ontario Hydro.

The claim in Hopkins v. Kay was brought by 280 plaintiffs whose health records had been improperly accessed by hospital employees and then disclosed to third parties. It is also salient that the Superior Court rejected arguments made by the Hospital that Ontario’s PHIPA was a complete code and that Jones v. Tsige should be limited in its application to matters falling within the federal PIPEDA.

It was on this question of whether privacy legislation ousted the applicability of the common law cause of action that the Hopkins v. Kay decision was appealed to the Ontario Court of Appeal. In Hopkins v. Kay, the Hospital argued that applicable privacy legislation constituted a comprehensive code for protection of patient privacy, and thus rendered the common law tort of intrusion on seclusion inapplicable to the health care context. In support of this contention, the Hospital referenced caselaw from British Columbia and Alberta — privacy statutes have been judicially determined to “occupy the field and preclude resort to common law remedies”. The Court of Appeal rejected this argument holding that the establishment by legislation in British Columbia and Alberta of general statutory causes of action for privacy breaches distinguishes those jurisdictions from Ontario. The Ontario Court of Appeal in Hopkins therefore, has confirmed that the tort of intrusion on seclusion might be available in a broader range of circumstances than those conforming precisely to the facts of Jones v. Tsige. At a minimum, what is clear after the Hopkins and Hynes is that hospitals and health care providers cannot confidently disregard the prospect of significant civil liability for privacy breaches.

The Hopkins decision, like Hynes, is an interim proceeding. How the case will ultimately be resolved remains to be seen. It does not bode well for the defence that the Superior Court ordered $24,000 in costs against the hospital for bringing the motion to dismiss the claim to begin with. Again, this is not a final damages award — the quantum of damages awarded will be much higher if the plaintiffs succeed in their claim.

**The Tort of Public Disclosure of Private Facts**

Recently, in January of 2016, the Ontario courts also confirmed that civil liability in tort for privacy breaches can extend beyond “intrusion on seclusion”. In Doe 464533 v. D., “revenge porn”, or the public upload of sexually explicit material without the consent of a female participant in the footage was held to constitute an actionable intentional tort, specifically: “public disclosure of private facts”. An 18-year-old woman had provided an intimate video of herself to a former boyfriend, who became the defendant in the case. That boyfriend uploaded the video online the same day he received it, and showed it to mutual acquaintances of his and the plaintiff’s. The woman became depressed, and suffered in a variety of ways. Ultimately, she sued. The court applied the existing doctrines of breach of confidence, invasion of privacy, and intentional infliction of mental distress. The judgement awarded general, aggravated, and punitive damages, injunctive relief, and ordered a publication ban. The quantum of the award was relatively low (approximately $140,000 including damages, interest, and costs) but it would not be safe to rely upon this number for future cases, because the plaintiffs had brought the case under Ontario’s Simplified Procedure Rules, and had
thereby agreed to a $100,000 claim limit. In fact, the court held that damages for public disclosure of intimate images were akin to those which would be suffered in the context of a physical sexual battery.

Civil Liability Risks Borne by Healthcare Professionals

The potential applicability of the tort of intrusion on seclusion to the health care context presents significant risks of liability to medical professionals, be they physicians, nurses or allied health professionals. It also presents hospitals and other institutional care settings with a risk of liability when dealing with patient information. Liability under tort law seems to be a realistic prospect in Ontario and Newfoundland and Labrador, while statutory liability is provided for in Alberta and British Columbia. Further, the development of the tort of public disclosure of private facts has potential application to the context of any disclosure of patient health data, including medical images.

It is of concern that the possible harms that could arise from privacy breaches relating to medical records are more profound than those for which damages have been awarded for intrusion on seclusion.

The peeping at banking records that gave rise to liability in Jones v. Tsige, while of longstanding duration, and in relation to materials that were technically private and confidential, and the curiosity-driven peering at health records in the Hynes and Hopkins cases, while irksome, are far less profoundly harmful conduct than the ways in which improperly accessed medical images could be used. Improperly accessed personal images in health records can easily be much more intimate that simple statements of a person’s financial worth. Diagnostic images, in their innate physicality, are more personal than monetary ones. Cell phone photographs of a person’s body, be they of skin conditions, tumours, fractures, surgery, problems with internal organs or other medical conditions, are very intimate.

If improper viewing of patient demographic data can give rise to liability, insecure storage of patient images might produce a greater risk of a higher damage award, whether under privacy legislation or tort law. Consider for example the Durham case, a class action brought under PHIPA after a nurse misplaced a memory stick containing personal health records about patients vaccinated for H1N1. Video footage of a person undergoing a surgical procedure presents them in a very vulnerable state. Viewing this kind of photographic record might be construed as a non-consensual exploration of a person’s body, and a fundamental violation of their autonomy and bodily integrity. Liability for breach of privacy in relation to these kinds of records might earn high damage awards. It is not at all beyond the realm of possibility that such remedies could include an award of punitive damages.

If personal information about a patient is shared without consent, or otherwise mishandled, including if information stored without proper security is accessed without the care provider’s knowledge or consent, a health care provider runs the risk of financial liability as well as a loss of reputation in the community.

Managing the Risks

Ethically, obtaining consent, ensuring secure storage of patient data, records and images, is the right thing to do, and is a legal obligation pursuant to PHIPA. Failure to ensure the security of patient records poses high risks of costing health care professionals and institutions a great deal of money. This was always true, but it has never been truer than it has recently become with the advent of the new tort of intrusion on seclusion and its application to the health care context.

Individual lawsuits against health care providers produce stress, strain, financial costs and increases
to insurance premiums. Additionally, physicians and other health care providers run the risk of their professional insurance policies not covering damages awarded in a tort lawsuit depending upon the specific terms of the policy in question. Further, privacy breaches could likely constitute professional misconduct and lead to disciplinary proceedings.

Worse, the prospect of class action lawsuits by groups of patients against hospitals and health care professionals looms large as a significant risk of the failure to store patient data securely. While neither Hopkins and Doe relate directly to electronic data security, as they concerned intentional violations of privacy, they speak to an increased risk of privacy-related liability generally, that presents prospective liability risks in the context of data storage and security. Further, Durham related directly to data storage. Such lawsuits can end with settlements or judgments in the multiple millions of dollars and can be the type of crisis event that can terminate the viability of a practice or institution.

The risk of harm to patients from failures on the part of medical professionals or institutions to store data, and in particular images, securely, or to have protocols, policies, and training in place to ensure this storage is done properly, is foreseeable. In consequence, it is highly likely that a court would find the standard of care for professionals and health care institutions to include making more detailed provisions for secure data storage in addition to those currently set forward. Fortunately, it is not that difficult or expensive for health care professionals and institutions to ensure that data is stored securely. Further, while it might not be without a cost, timely risk management could be undertaken by hospitals and other institutions through training and education of staff as well as development of comprehensive and thoughtful policies and protocols pertaining to how to access medical records, and be consistent with PHIPA.

[Editor’s note: Dr. Rebecca Jaremko Bromwich, Ph.D., LL.M., LL.B., B.A. is a lawyer and law professor who teaches Torts at the University of Ottawa Faculty of Law as well as several courses in the Law and Legal Studies Department at Carleton. Dr. Bromwich may be reached at <rebecca.bromwich@carleton.ca>.]

The Ethical and Legal Dilemma in Terminating the Physician-Patient Relationship

Dr. Helen Senderovitch

Abstract

A physician-patient relationship is essential for the well-being of the patient, for without a strong and trusting relationship between both individuals, the patient may not receive the best care that they deserve. There are many legal policies and ethical principles a physician must follow when caring for a patient. It is both the legal and moral duty of the physician to act in the best interests of their patients, while making sure to respect them regardless of background and personal behaviours. The relationship is secured with both trust and respect, for without trust, the patient may hold back from stating their conditions which will result in the physician not providing them with all the care they require. Sometimes, lack of some of these key characteristics of the physician-patient relationship and other circumstances, may cause either the patient or the physician to terminate the relationship. Termination of a relationship creates a difficult situation for the patient, and therefore there are only specific situations where a physician may have permission to follow through and terminate their relationship. Both the law and ethical principles play a role in the decisions made by the physician in regards to their relationship with the patient, but regardless, the physician has the obligation to make sure their patient is receiving care by one means or another.

This paper presents two case vignettes to describe the relationship between ethics and law as well as emphasize its role in a physician-patient relationship. Many complex clinical scenarios such as those described below are found to be a reality in many health care facilities. The paper also looks into the protocol that must be followed when terminating a relationship, and the reasons that allow a termination to take place. A physician should not feel obligated to treat a patient who makes them feel unsafe and/or uncomfortable. On that note, a patient should not feel obligated to be treated by a physician who makes them feel unsafe and/or neglected. Therefore, physicians and patients must be aware of the circumstances under which a physician-patient relationship can be terminated. Having relationships where one feels unsafe or uncomfortable only jeopardizes the quality of the patients’ care. Hence, having physicians and patients learn about terminating a physician-patient relationship, will help to improve the quality of medical care in Canada.

Mrs. A & Dr. Y

Mrs. A is a 61-year-old female patient in a long-term care facility who has been abusing tobacco for some time. She has multiple comorbidities, a history of mental illness and COPD. She recently underwent emergency hernia repair. Her attempts to refrain from smoking resulted in improvement of the healing of her wound, but it opened every time she went back to her habit of smoking. Mrs. A, after much encouragement, enrolled in a smoking cessation program and tried to follow the program’s regimen, but slipped back to a pattern of heavy smoking. Moreover, her behaviour is very challenging for staff and fluctuates on a daily basis. She is getting frustrated with Dr.’s Y inability to help her with healing her wound and decides to dismiss Dr. Y.
Mr. B & Dr. Y

Mr. B is an elderly individual who is a resident of long-term care. Despite his understanding of the impact of smoking on his previous and current health, he has not been able to stop. He has multiple comorbidities, including mental illness, diabetes, and coronary artery disease with a couple of angioplasties in the past. He is believed to possibly be in need of another angioplasty due to his increased symptoms of myocardial ischemia with recurrent chest pain, and his inadequate responsiveness to attempted medications. But, if an angioplasty is too risky, such as in this case scenario, it would fall outside the standard of care and would outweigh any anticipated benefits. Therefore, due to persistent multiple comorbidities, angioplasty would not be offered, despite whether or not the patient continued to smoke. On the other hand, if it fell within the standard of care and the patient still smoked, an angioplasty must be performed, since denying the patient an angioplasty will then be a violation of the Human Rights Code.

In the case of Mr. B, he was provided with a gamut of pharmacological interventions in the past to help him to give up his habit of smoking, but he couldn’t tolerate them due to side effects. Moreover, he is emotionally unstable with frequent outbursts of verbal abuse towards staff. Dr. Y is getting frustrated with his abusive behaviour and inability to commit to his treatment. He is concerned about possible complications to Mr. B’s health due to his tobacco consumption and his own potential liability. As a result, he decides to remove Mr. B from his practice and refer him to Dr. Z.

When is it Appropriate to Terminate the Physician-Patient Relationship?

Before the physician or patient decides to terminate a relationship, it is important that they realize the option is a last resort. There are four generally accepted common law mechanisms which govern the conditions by which the physician-patient relationship may be terminated. First, the patient may choose to dismiss the physician, as in the case with Mrs. A. In this case, there is no need for the physician to provide a notice of termination and the legal duty to treat ends immediately. The patient is entitled to the information contained in his/her medical records. It would be helpful if physicians could discuss the option of terminating a relationship when they accept patients into their practice. Perhaps the patient should be warned and informed about the possibility of termination in the form of a contract which the patient can read and understand.

Second, the physician and patient may mutually decide to end the relationship. Third, the relationship may be terminated automatically when the patient is no longer expected to return for care. This occurs, for example, when a patient chooses to receive plastic surgery, and the post-operative follow-up checks are completed and the patient no longer needs care from the physician.

Last, the relationship is terminated when the physician withdraws from providing care for their patient. In the case of Mrs. A, before termination, she must be warned about possible health complications if she decides to continue smoking. If she understands, and yet accepts the risks, the relationship may still continue, since choosing to smoke is a life choice that she is entitled to make. Therefore, as her physician, Dr. Y should respect her wishes regardless of his opinion. But, in the case that Mrs. A continues to demand treatment despite the risks involved, Dr. Y may feel uncomfortable with continuing to treat her, and so may move forward with the procedure for terminating the relationship. In our case, Mrs. A decided to terminate the relationship herself. In such a situation, as her physician, Dr. Y still has the legal obligation to make sure that Mrs. A is able to understand and appreciate her decision. There are many reasons as to why a physician may choose to terminate a relationship. One of the key
reasons is when there is no longer trust and respect in the relationship — two of the essential characteristics of a physician-patient relationship. Over the course of a relationship, through certain situations, the physician may find a breakdown of these elements. Patient fraud, by means of the patient obtaining other drugs such as illicit drugs, and narcotics without consent, displays a breakdown of trust. It must be noted that if a patient is referred to a specialist and the specialist gets consent to start medication, any other physician involved in that patient’s care does not need to consent to the initiation of the medication. Also, a patient who is verbally abusive or physically threatening to the physician displays a breakdown of respect and communication, as in the case with Mr. B. This leads to the following questions:

Does Dr. Y have the professional duty to retain Mr. B as a patient under all circumstances? Is the non-adherence and verbal abuse of Mr. B an ethically appropriate reason for Dr. Y to attempt to remove Mr. B from his practice and refer him to another physician? A patient’s non-adherence if it poses an immediate danger to the patient and verbal abuse towards the physician, is a valid reason for the physician to have the relationship with the patient terminated. In fact, there is a duty to warn if a patient demonstrates behaviour which may cause harm to him/herself or others. Therefore, Dr. Y has an appropriate reason to remove Mr. B from his practice, but Dr. Y must find another physician for Mr. B before terminating the relationship. Moreover, Dr. Y must ensure that transferring Mr. B to another physician such as Dr. Z, does not put the patient at a disadvantage, and that emergency care is provided whenever necessary.

Moreover, a physician may choose to terminate the relationship if the patient’s non-adherence with treatment poses an immediate danger to him/herself and potential liability to the physician, as in both of our cases (Mrs. A and Mr. B). Lack of communication also serves as a key reason to terminate, for without communication the physician will not be able to provide the most appropriate care for the patient. Patients feel respected when they are listened to, and their questions are answered. This will lead both sides to speak honestly with each other, which is key to a physician-patient relationship. Respect is known to strongly reflect the core aspects of patient-centered care, and as a result positively having an impact on the patient’s autonomy, integrity, dignity and honour. A patient who feels respected will be encouraged to speak openly to their physician, and thus receive the treatment that will best serve their needs. Once there is openness and trust in the relationship, the patient will be less fearful, and thus better adhere to the treatment suggested by the physician.

Another factor that may result in termination of the physician-patient relationship is if there is a conflict of interest between the patient and the physician. For example, the physician’s religious beliefs may preclude him/her from providing certain treatment options, or the physician may have a personal or financial interest in the treatment option.

A conflict of interest can lead to termination of the physician-patient relationship if this conflict compromises the physician to put the interests of his/her patients first, which is his/her legal duty. In our case, Mrs. A decides to terminate the relationship, but what would happen if Dr. Y is disappointed with Mrs. A’s inability to commit to her treatment and he decides to remove Mrs. A from his practice and refer her to Dr. Z?

Dr. Y decides to do this due to his concern about possible complications to Mrs. A’s health as a result of her inability to refrain from smoking, and Dr. Y’s willingness to reduce his exposure to potential liability. These two reasons are valid, but Dr. Y must make sure that this is of last resort. If so, Dr. Y must make sure that Dr. Z can provide Mrs. A the treatment she requires and then proceed...
with the necessary legal paper work. But, before doing so, Dr. Y must inform Mrs. A of the reason for terminating the relationship.

If another physician is not found for Mrs. A, Dr. Y is still responsible for providing treatment in the case of an emergency. This means that if Mrs. A is in need of care, regarding a condition which requires immediate attention, Dr. Y is responsible to provide care. Not providing care will result in abandonment of the patient.

Under the *Personal Health Information Protection Act, 2004*, a health care provider may provide the personal health information about a patient to another health care provider for the purposes of providing health care or assisting in the provision of health care to the patient. The Act also gives patients the right to expressly restrict his/her physician from providing another health care provider with their personal health information. In this case where a physician is asked by another health care provider for information about a patient that is reasonably necessary for the provision of health care to the patient, the physician must notify the other health care provider that he/she had been restricted from disclosing information about the patient, unless the disclosing of information results in harming the patient or others. If there is no possibility of causing harm, the patient’s physician must then tell the health provider to direct any inquiry to the patient.

In our case with Mr. B, what should Dr. Y do if Dr. Z does not wish to accept Mr. B as a patient?

If this occurs, Dr. Y must find another physician who can provide care for Mr. B. If no other health provider is found, Dr. Y is responsible to provide care, including emergency care for Mr. B until another provider is found.

The College Physicians and Surgeons of Ontario Policy states that Ontario is currently lacking in human health resources, and as a result is putting physicians in a position where they may have too many patients to provide their services for. As a result, physicians may have to terminate some of their relationships with patients. It is advised that when a physician is faced with such a situation, they should consider the medical needs of the patients and find another source of care, making sure that the patient is not put at a disadvantage. Therefore, both the patient or the physician are legally able to decide whether or not they would like to terminate the relationship, but the physician must consider both the legal (act according to Ontario Human Rights Code) and ethics behind their decision, because their decision may potentially put their patient at a disadvantage.

In our case, Mr. B, is an immigrant from a culture where smoking is a way to both interact socially with others and interact in job-related situations. For a person for whom smoking is a way to become a member of society (a society which enables them to grow as an individual), smoking may be construed as an almost mandatory practice. Therefore, there is a profound environmental influence on their personal practices. Since genetics and the environment are beyond our control, one might interpret such resultant actions of humans beyond their personal choice alone. As a result, a physician must not simply choose termination as the only option if a patient is unable to quit smoking, because sometimes it is beyond their control. That’s why a physician must not only consider the legal circumstances in which they may be able to terminate the relationship, but to also look at the situation from an ethical perspective to see if what legally seems acceptable, will provide the patient with a benefit or a disadvantage.

**Procedure to Terminate Patient-Physician Relationship**

If a decision is made to terminate a physician-patient relationship, it needs to be put in writing, along with having the patient’s condition evaluated and stabi-
lized. Also, a letter must be signed by the physician, and be sent to the patient’s home by regular and certified mail with a return receipt requested.

Before completely ending the physician-patient relationship, the physician must do one of two things to avoid legal liability for abandonment of the patient. They must either provide a suitable substitute physician who can meet the patient’s health care needs, or give the patient reasonable notice so that the patient can find a replacement physician. If a transfer cannot be arranged, the patient must be accepted and the medical relationship resumed. If this occurs and the medical relationship remains unsatisfactory to the physician, the entire termination process must be repeated. If termination of the relationship occurs, and the patient returns to the facility on an emergency basis, it is necessary for the physician to treat and stabilize the patient prior to transferring him/her to another physician.7

When is it not Appropriate to Terminate a Patient-Physician Relationship?

The Ontario Human Rights Code plays an important role in the career of a physician. A physician cannot terminate a patient-physician relationship based on any prohibited ground in the Human Rights Code. This includes, race, sex, religious beliefs, gender identity, marital status, etc. This means that a physician cannot refuse to provide care to a patient on the basis of a prohibited ground such as sex or sexual orientation, even if the refusal is due to the moral or religious beliefs of the physician.8 Though not included in the Human Rights Code, a physician also cannot discriminate based on financial circumstances. Therefore, if a patient chooses not to pay a fee, a physician cannot use that as a valid reason to terminate the relationship.9 Moreover, a patient is entitled to make decisions related to their health, even if the physician may not agree with the decisions. Therefore, the only time a physician is allowed to terminate the relationship is if the decision being made creates a liability for themselves. Most importantly, and as mentioned above, emergency care should be provided in any circumstances. Therefore, in times of an emergency, termination of the relationship does not hold and care must be provided by the physician.

Abandonment

If a physician decides to terminate a relationship based on the prohibited grounds outlined in the Human Rights Code, such as race, sex, religious beliefs, including financial circumstances which stands on its own, and/or if he/she does not follow the legal protocol while terminating a relationship, the patient can file a claim for being abandoned by the physician. Patient abandonment has been defined as unilateral withdrawal by a physician from a patient’s care without promptly formally transferring that care to another qualified physician who is acceptable to the patient.

Abandonment is not only ethically problematic, but also another defining act of unprofessional conduct which may lead to revocation, suspension, limitation or restriction of a physician’s license. In order to state abandonment, the patient must prove that the physician: (a) unreasonably discontinued medical treatment, (b) against the will of the patient, (c) without arranging for a substitute physician and, that (d) the physician has some reason to know that physical harm may result to the patient and the patient in fact suffered physical harm as a result of the discontinued treatment.

Therefore, even though the physician decided to terminate care for a patient, he/she may not simply inform the patient without making a referral or agreeing to continue to provide care for a certain period of time during which the patient finds a substitute, otherwise the physician risks a lawsuit by the patient claiming abandonment. Moreover, if the patient is denied emergency care, and/or if the relationship is terminated without warning or complete transfer of care, the physician will be
abandoning the patient, and this can lead to negligence. In our case, if Mr. B does not want to change doctors, and the physician-patient relationship is terminated without finding a replacement and/or providing emergency care, it will be referred to as abandonment.

**Conclusion**

A physician must abide by laws put in place and act in the patient’s best interests, but sometimes circumstances arise where a physician is no longer able to provide care without putting him/herself or the patient at risk or disadvantage. It is in such a situation, where the physician must decide to terminate the relationship. It is important that in doing so he/she is not abandoning the patient. This is because, regardless of the physician’s inability to provide care, they are still obligated to make sure the patient is receiving the care he/she needs. Legally, physicians can withdraw from the relationship and withhold providing a reason, as long as certain procedural standards are upheld. However, the ethical consequences of such actions without rational and justifiable reasons are a different matter, potentially leading to disrespect and distrust of the individual physician and compromising the public trust and confidence in the profession as a whole.

Many challenges as those outlined above in the described cases may arise during care, and it is important that physicians act in both an appropriate legal and ethical manner in order to meet the needs of their patients who are part of the greater society. Therefore, a physician must look at both the legal and ethical side of the decisions they are making, as their decisions not only affect their patients, but society’s view toward the practice of medicine.

[Dr. Helen Senderovich, MD, MCFP COE PC, is a physician at Baycrest Health Sciences System with a practice focused on Palliative Care, Pain Medicine and Geriatrics. She is a lecturer at the Department of Family and Community Medicine and the Division of Palliative Care at the University of Toronto. She is an author of several manuscripts focused on geriatrics, patient-centered care, ethical and legal aspects of the doctor-patient relationship and palliative and end-of-life care. Dr. Senderovich can be contacted at <hsenderovich@baycrest.org>.

5. Supra, note 2.
8. Supra, note 2.
9. Ibid.

Dr. J. Douglas Salmon, Jr., Dr. Jacques J. Gouws & Corina Anghel Bachmann

Abstract

This three-part paper presents practical holistic models of determining impairment and occupational disability with respect to common “own occupation” and “any occupation” definitions. The models consider physical, emotional and cognitive impairments in unison, and draw upon case law support for empirically based functional assessment of secondary cognitive symptoms arising from psychological conditions, including chronic pain disorders. Case law is presented, primarily in the context of Ontario motor vehicle accident legislation, to demonstrate how triers of fact have addressed occupational disability in the context of chronic pain; and interpreted the “own occupation” and “any occupation” definitions. In interpreting the definitions of “own occupation” and “any occupation”, courts have considered various concepts, such as:

- work as an integrated whole
- competitive productivity
- demonstrated job performance vs. employment
- work adaptation relative to impairment stability
- suitable work
- retraining considerations
- self-employment, and
- remuneration/socio-economic status.

The first segment of the paper reviews the above concepts largely in the context of pre-104 Income Replacement Benefit (IRB) entitlement, while the second segment focuses on post-104 IRB entitlement. In the final segment, the paper presents a critical evaluation of computerized transferable skills analysis (TSAs) in the occupational disability context. By contrast, support is offered for the notion that (neuro) psychovocational assessments and situational work assessments should play a key role in “own occupation” disability determination, even where specific vocational rehabilitation/retraining recommendations are not requested by the referral source (e.g., insurer disability examination).

Introduction

Treating rehabilitation and clinical psychologists, as well as clinical neuropsychologists working in the rehabilitation field, are commonly called upon to provide disability opinions regarding Motor Vehicle Accidents (MVA), Workplace Safety and Insurance Board claims (WSIB), and Short and Long Term Disability claims (STD, LTD). Colleagues working in the related fields of forensic psychology or medical legal and insurance assessments, have such questions posed as part of their daily work. While it is incumbent upon clinicians working in both sectors to keep abreast of the evolving case law pertaining to disability test interpretations, often doing so is complicated by the lack of readily accessible judicial and arbitral decisions. This paper attempts to provide a brief, current resource that summarizes key decisions primarily in the Ontario MVA domain.

It is incumbent upon disability assessors to consider the whole person in all areas of functioning, and not to limit the assessment to one area, or give it
too narrow a focus. In this regard, the authors take guidance from the statement of Arbitrator Wilson in Thangarasa and Gore Mutual, [2005] O.F.S.C.D. No. 44 (FSCO A02-001360, April 1, 2005):

While it is important that assessors stay within the range of their own expertise, it is also important that they not ignore limiting factors, even if they stem from matters outside of their own competence.

Presently in Ontario, MVA case law is formulated by judicial decisions rendered at the various civil court levels, as well as decisions of the alternative dispute resolution (ADR) arm of the Financial Services Commission of Ontario. The Financial Services Commission of Ontario’s (FSCO) ADR branches include mediation and arbitration services; but it is the arbitration branch which serves the evolving case law. While arbitrators are not bound to follow court decisions or even other arbitral decisions, they do play an important role in fleshing out further details and clarifying aspects and principles of the Ontario MVA legislation. In other words, in their daily proceedings, arbitrators must interpret the law and in particular, the Statutory Accident Benefits Schedule (SABS), including the varied disability definitions.

However, this is all about to change. On March 4, 2014, the Ontario Liberals announced the Fighting Fraud and Reducing Insurance Rates Act. Some of the changes will come into effect April 1, 2016, some June 1, 2016, while others are still being worked on. The Liberals are set to implement sweeping changes to the auto insurance accident system in Ontario — changes to both the substantive rights of Ontarians and the procedural steps to claim those rights. At the time this paper went to print, only a skeletal overview of these changes had been announced, with many of the details still missing. Below is a summary of the most significant changes, as they are currently known.

Some of the more pertinent changes expected April 1, 2016 are:

- FSCO will cease to be the body adjudicating SABS disputes, except for ongoing arbitration hearings that have an arbitration number assigned.
- As of April 1, 2016, all SABS disputes will be dealt with by the Ministry of the Attorney General’s Licence Appeal Tribunal (LAT).
- LAT adjudicators have broad powers to determine the length and format of a hearing. Hearings can be held in writing, by phone, by teleconference or videoconference, or in-person.
- There is no right to cross-examine a witness, but LAT adjudicators may permit cross-examination.
- LAT adjudicators are not bound by the wealth of case law established by FSCO arbitrators or our courts.
- Claimants have been stripped of their rights to pursue their claims in court. With the exception of a very limited right to appeal, claimants are restricted to the resolution system provided by the LAT.
- A decision of a LAT adjudicator can only be appealed on a question of law.

While the LAT is not a new tribunal, it does not have any experience dealing with automobile insurance disputes. As such, giving LAT adjudicators such sweeping powers, with very little oversight, and stripping claimants of their right to pursue disputes in our courts, is making many in the industry uneasy. While the goal of the LAT — to process SABS disputes in a timely fashion — is laudable, the concern of many is that quality of service will be sacrificed in the name of speedy resolutions.

Many of the details of how the LAT will handle the sometimes complicated nature of accident benefit
disputes remain unknown. It is hoped that while LAT adjudicators are not mandated to follow previous FSCO or court decisions, these will nevertheless remain persuasive, and that when it comes to complex and sophisticated SABS issues that have been the subject of arbitral and court decisions, the wealth of knowledge accumulated over the years will be preserved and applied to allow for some predictability in the new dispute forum.

With this in mind, this paper continues to rely on the case law and arbitration decisions that have interpreted the relevant SABS provisions over many years.

To understand the evolution of the disability tests in case law, practicing clinicians should be aware of the following important considerations:

1. The legal basis of the interpretation of a disability test must inform the clinician’s own interpretation in applying the respective test;

2. The clinician should use best practices in his or her assessment in order to establish the evidence base to support the disability analysis and opinion; and,

3. The clinician must consider both the evolution of disability tests interpretation as defined by case law; and the related evolution of disability assessment/analysis methodology.

To illustrate the importance of the above principles, the authors will analyze the definitions of the two income replacement benefit (IRB) tests in the context of the SABS and the Ontario MVA legal framework.

**Ontario MVA Legal Framework**

The Ontario MVA system is a hybrid no-fault and tort based approach. The SABS grant an injured person the right to certain benefits, provided that specific tests are met. Generally speaking, the SABS establish entitlement tests for IRBs, and three tiers of treatment provision/provider fees, housekeeping benefits, attendant care benefits, and case management services. The three tiers are: injuries that fall within the Minor Injury Guidelines (MIG), injuries that are deemed to be catastrophic (CAT), and those that are neither MIG nor CAT (the “regular stream”). Some of these basic entitlements/benefits are:

(a) **Homecare and caregiving benefits.** Since September 2010, homecare is only available to claimants with catastrophic impairments.

(b) **Non-earner benefits.** Currently, these benefits are available to all claimants who meet the eligibility test, after a six-month waiting period. For accidents after June 1, 2016, non-earner benefits remain available to all claimants, but will terminate two years after the accident except for CAT claimants, with the initial six-month waiting period reduced to four weeks.

(c) **Treatment.** Currently, the total medical-rehabilitation benefits available to MIG claimants is $3,500. On the other end of the spectrum, claimants who have suffered catastrophic impairments, are entitled to a maximum of $1 million of medical and rehabilitation benefits over their lifetime. Claimants whose injuries fall within the “regular stream” can access up to $50,000 of medical and rehabilitation benefits over a 10-year period.

(d) **Attendant care benefits.** Currently, these benefits are not available to MIG claimants. Claimants in the “regular stream” can access up to $3,000 of attendant care benefits per month, for up to two years post-accident, for a total of $36,000. Catastrophically injured claimants can claim a maximum of $6,000 per month, for a total of $1 million over their lifetime.

(e) **As of June 1, 2016,** the treatment and attendant care benefits available for CAT and “regular stream” claimants have been amalg-
mated and reduced. The “regular stream” claimants will see their medical and attendant care benefits reduced from $86,000 to $65,000 (inclusive of the cost of assessments and reports), with a maximum duration of five years, while CAT claimants will see these benefits slashed in half to a total of $1 million for treatment and attendant care benefits combined. No changes have been announced for these benefits for MIG claimants.

(f) **Case management services** are automatically provided to those with CAT status, but there is no entitlement to same for non-CAT claimants. This is the case both before and after June 1, 2016.

For the most part, the right to claim certain or various accident benefits is categorized by time period (pre-104 weeks versus after 104 weeks); and degree of impairment (MIG versus catastrophic versus non-catastrophic impairment).

Entitlement to IRBs, however, is premised not on the seriousness of the injury, but on meeting the “own occupation” test for entitlement to “104 weeks of disability” benefits. For most cases, “104 weeks of disability” will coincide with “104 weeks from the accident”, but there can be exceptions to the rule, as in cases where insureds return to their job following the accident, but then stop working when their condition deteriorates. The period of time during which they are back at work is part of the “104 weeks from the accident”, but should not be counted as part of the “104 weeks of disability”.

Entitlement to other SABS benefits also depends on whether a claimant is found to be catastrophically impaired or not. CAT impairment, a legal concept defined in the SABS, is often the subject of much dispute, as it grants a claimant access to greatly increased benefits over a longer period of time. Aside from CAT status, consumers also have the option of buying increased benefit coverage, although statistics show that this option is rarely exercised.

Entitlement of a claimant to accident benefits is subject to the concept of “reasonable and necessary”. While CAT status determines maximum amounts available for service provision and the length of time over which such services can be provided, eligibility for any given service remains subject to the “reasonable and necessary” test for both CAT and non-CAT cases. The legal definition of “reasonable and necessary” services has, and continues to evolve with case law interpretation. Review of this aspect of jurisprudence is beyond the scope of this paper.

Significant changes have also been implemented in tort. While the verbal threshold remains unchanged — a claimant can only recover damages for pain and suffering if he or she has sustained a serious and permanent impairment of an important bodily function, and/or a mental and psychological function — the monetary threshold, or deductible, is now set to increase on a yearly basis to reflect the rate of inflation. As of January 1, 2016, and every subsequent year, the basic $30,000 deductible will be adjusted by the indexation percentage to be published under subs. 267.1(1) of the *Insurance Act*. Pecuniary damages such as loss of income, loss of ability to perform household chores and medical & rehabilitation needs must be proven on a balance of probability; and are not subject to a verbal or monetary threshold.

As a starting point, it is important to understand the underpinnings of the Ontario MVA system’s definition of impairment and disability. The definition of “impairment” used within this system is generally consistent with the historical definition published by the World Health Organization (though since modified), which defines an impairment as “a loss or abnormality of psychological, physiological, or anatomical structure or function”.

Rather than adopting a specific operational definition of “disability”, similar to other jurisdictional approaches, the Ontario SABS define disability on the
basis of the respective entitlement tests: income replacement benefits, non-earner benefits, caregiver benefits, and homemaking/housekeeping benefits. The tests are further defined on the basis of whether the benefits are claimed before or after 104 weeks/two years post-accident. The specific legal tests for the SABS benefits are provided in the table below.

### Comparison of MVA Disability Definitions

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Test — Pre 104 weeks/2 years of disability/from the accident</th>
<th>Test — Post 104 weeks/2 years of disability/from the accident</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Income Replacement Benefit (IRB)</strong></td>
<td>As a result of and within 104 weeks after the accident, the insured person suffers a substantial inability to perform the essential tasks of his or her employment.</td>
<td>As a result of the accident, the insured person is suffering a complete inability to engage in any employment for which he or she is reasonably suited by education, training or experience.</td>
</tr>
<tr>
<td><strong>Caregiver Benefit (CGB). Available only to CAT claimants.</strong></td>
<td>As a result of and within 104 weeks after the accident, the insured person suffers a substantial inability to engage in the caregiving activities in which he or she engaged at the time of the accident.</td>
<td>As a result of the accident, the insured person is suffering a complete inability to carry on a normal life.</td>
</tr>
<tr>
<td><strong>Non-Earner Benefit (NEB) before June 1, 2016</strong></td>
<td>As a result of the accident, the insured person is suffering a complete inability to carry on a normal life.</td>
<td>As a result of the accident, the insured person is suffering a complete inability to carry on a normal life.</td>
</tr>
<tr>
<td><strong>Non-Earner Benefit (NEB) after June 1, 2016</strong></td>
<td>As a result of the accident, the insured person is suffering a complete inability to carry on a normal life.</td>
<td>Only available post-104 weeks if claimant has sustained catastrophic injuries.</td>
</tr>
</tbody>
</table>

This paper shall review the relevant case law, and the methodology and interpretation of the clinical disability assessment/analysis, as applied to the two IRB tests. Less emphasis will be placed upon the pre-104 week caregiver benefit entitlement test, but suffice to say that it lends itself to the same principles as the pre-104 week IRB test: wherein the pre-104 week IRB test considers the “essential tasks” of an individual’s pre-accident employment, similarly, for the first 104 weeks following an accident, the caregiver test focuses on the primary caregiving activities (akin to essential job tasks) that an individual was involved in at the time of the accident. It is important to emphasize that unless stated otherwise, the case law examples provided below generally reflect long established case law principles, and therefore multiple citations are often not indicated.

### Pre-104 Week IRB Disability Test

The pre-104 week IRB test is defined in the Ontario SABS as follows:

as a result of and within 104 weeks after the accident, the insured person suffers a substantial inability to perform the essential tasks of his or her employment.

In interpreting this test, the focus is on the phrases “substantial inability” and “essential job tasks”.

The key words in the respective phrases are the qualifiers “substantial” in reference to “inability”; and “essential” in reference to “job tasks”. The following Venn diagram (Figure 1) helps to convey these respective terms. The individual’s impairments are depicted on the left hand side, with the outer most circle reflecting the overall impairments,
and the inner circle reflecting “substantial impairments”. On the right side of the diagram, overall job tasks are represented by the outer most circle, and the “essential job tasks” are represented by the inner circle. A “substantial inability to perform the essential job tasks” is thus defined as the intersection of the “substantial impairments” and “essential job tasks”. The depiction is meant to be comprehensive, such that both impairments and job tasks are inclusive of physical, cognitive, emotional and interpersonal spheres.

**Figure 1. Substantial inability to perform essential tasks of employment**

The following graphically based model (Figure 2), fleshes out the above concept further with specific reference to the key assessment types which are germane to each impairment and related disability domain sphere. The first row of variables depicts impairment/diagnostic categories across physical, emotional and cognitive domains. Below each of these categories is listed the specific assessment modality of choice, to best address the impairments within the related sphere. By contrast, the bottom of the graph reflects the occupational demands and the tools utilized in order to detail those job demands and identify among them the “essential” job demands. While the Physical Demands Analysis (PDA) is well known and utilized within the rehabilitation industry, less well known and used are tools to evaluate the emotional, psychological and interpersonal (together with psychosocial) job demands. Addressing the cognitive job demands is also a critical facet. Within our own practice, and seemingly emerging in the field, is a methodology entitled the “Cognitive-Psychological Job Demands Analysis”, meant to comprehensively address all the psychological-cognitive elements within one evaluation procedure. Alternate and converging approaches to a comprehensive (tripartite) occupational work assessment, might occur under such titles as “Job Demands Analysis” (JDA) or “Comprehensive JDA”, or similar terms.

Finally, in order to establish the intersecting points of the above Venn diagram (i.e., potentially intersecting points for each of the three impairment/demand domains), and to evaluate the claimant’s capacities relative to the essential job demands, one must distinguish functionally based measures from impairment based measures. Again, it is standard in the industry for assessors to use functional ability/capacity evaluations to measure a claimant’s physical abilities relative to essential job demands. Less popular, but just as important, are specialist vision, hearing, balance or related assessments. These evaluations can be important adjuncts to functional capacity evaluations for those clients with primary sensory and motor impairments, and can help address the issue of potential physical harm/condition aggravation in the context of specific work demands.

The Neuropsychological Evaluation is commonly used to consider the client’s cognitive and emotional capacity relative to respective job demands. Less used, but not less essential, is the Cognitive-Psychological Functional Ability Evaluation (CP-FAE), particularly in the context of mental health impairments. Like their physical counterparts, clinical psychological and psychiatric assessments are important adjuncts to consider more pronounced mental health diagnoses and conditions, in lieu of, or in combination with more
functionally oriented assessments. As an alternate and synergistic approach to these distinct functional methodologies, one could also utilize a job trial or situational work assessment (employing simulated work tasks), to evaluate the claimant’s capacity to simultaneously manage physical, cognitive and psychosocial work demands in the context of the whole person and related impairments.

**Figure 2. Impairment and “own occupation disability determination**

![Diagram: Impairment & “Own Occupation” Disability Determination](source)

Dr. J. Douglas Salmon, Jr. © 2001, 2006

### Pre-eminence of Essential Cognitive Job Tasks

The importance of cognitive and emotional/interpersonal job demands on employees have traditionally been underemphasized and underrepresented in the disability assessment field, despite the evolving importance of these work demands in the economy at large. In this regard, an article (Lysaght, et al. 2008) titled “Towards improved measurement of cognitive and behavioural work demands” and published in “Work: A Journal of Prevention, Assessment and Rehabilitation”, notes that determination of the cognitive and behavioural demands of work is an important part of holistic workplace intervention. The article, written from an occupational therapy perspective, observes that these factors are especially important when developing return-to-work programs for persons with reduced cognitive, behavioural or psychoemotional capacity, and when designing risk management programs in organizations. This is not new thinking. The comprehensive assessment of cognitive, personality, aptitude, and interest components as they relate to more advanced job tasks in particular, has been a long established practice in Industrial Organizational Psychology, where numerous landmark texts have emerged.

One such landmark work, for example, is *Industrial Psychology*, by McCormick and Tiffin, with a first edition that dates back to 1942. The Sixth Edition, published in 1975, provides a comprehensive overview of many of the human factors specific to the
work environment that need to be considered for successful employment, such as aptitude, intelligence, personality, social skills, etc. Work Psychology: Understanding Human Behavior in the Workplace, a 1991 book by Arnold, Robertson and Cooper, highlights the differences between “handicap” and “disability”. The authors note the 1985 Haggard differentiation as useful:

… disability refers to a reduced repertoire of generally valuable biological, physical, and social skills ... handicap refers to reduced personal, social, educational, economic, and cultural opportunities available as a consequence. (p. 77)

Thanks to the extensive and rapid developments in technology, the work environment has changed significantly, especially over the last two decades. As a result, the demands of the job tasks now include requirements for certain levels of function not previously expected of employees, particularly with respect to cognitive and interpersonal demands. This seems to be the case even for the more physically demanding workplace and the lower skill level jobs (Institute for Competitiveness and Prosperity, Martin Prosperity Institute, 2009).

Establishing Functional Brain Impairment Correlates of Post-MVA Psychological Conditions

In concert with the recognition that the workplace demands ever increasing emotional-interpersonal and cognitive skills, there is also emerging literature support for the link between common post-MVA pain related sequelae and functional brain impairment correlates.

Research suggests that pain-related negative emotions and stress potentially impact cognitive functioning independent of the effects of pain intensity. The anterior cingulate cortex is likely an integral component of the neural system that mediates the impact of pain-related distress on cognitive functions, such as the allocation of attentional resources. A maladaptive physiologic stress response is another plausible cause of cognitive impairment in patients with chronic pain, but a direct role for dysregulation of the hypothalamic-pituitary-adrenocortical axis has not been systematically investigated. (Hart, et al. 2003, p. 116)

A more recent MRI investigation by Baliki, et al. (2008) suggests that chronic pain itself may serve to directly alter brain functioning.

These findings demonstrate that chronic pain has a widespread impact on overall brain function, and suggest that disruptions of the [default mode network] may underlie the cognitive and behavioral impairments accompanying chronic pain. (p. 1398)

To further drive home this point, mental health clinicians will recall that virtually all major MVA related mental health diagnoses include within their DSM clinical criteria substantive cognitive and interpersonal impairments, including impairments related to Major Depression, Dysthymic Disorder, Generalized Anxiety Disorder and Post Traumatic Stress Disorder. To emphasize,

• All major mood and anxiety disorders include in their DSM diagnostic criteria:
  o cognitive symptoms

• All major mood and anxiety disorders require in their DSM diagnostic criteria:
  o “The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning”. (emphasis added)

Tying together both emerging neurophysiological correlates and long established diagnostic criteria, the importance of appropriately recognizing and measuring the cognitive and interpersonal impacts of MVA related (non-central nervous system based) psychological disorders must not be understated in the context of disability assessment.

Chronic Pain Based Entitlement to Benefits

From the clinical perspective, the psychological impact of pain has been studied and reported on in research articles for at least the past quarter century. The literature indicates that depression is one of the most common problems experienced by patients with chronic pain (Reich, et al. 1983). Ten years later, research shows that if pain results in a loss of independence or mobility that decreases an
individual’s participation in social activities, the risk of depression is significantly increased (Williamson and Schulz 1992).

The research literature going back 25 years shows that patients with chronic pain, when compared to those with almost any other medical condition, suffer dramatic reductions in physical, psychological, and social well-being, and their health related quality of life is lower (Atkinson, et al. 1991; Skevington 1998; Becker, et al. 2000). This has obvious and significant implications for the rehabilitation of individuals suffering from chronic pain and emotional injuries. Furthermore, the impact of pain in the workplace has been researched in several countries and there is consistency in the various findings. Some of these findings are very pertinent in the assessment of disability and rehabilitation in the context for which this article is written. The following quotations serve to educate disability assessors on the complexities involved in disability assessment. In this regard, an important study on disability published in Great Britain stated that:

Most studies find that mental disabilities have a more severe effect on employability than other forms of disability and severity of disability for all types increases the likelihood of inactivity in the labour market. There are also important differences between those born with a disability and those subject to disability onset, with the latter most subject to negative employment effects, particularly those with low levels of human capital. (Jones, et al. 2006, p. 21).

There are several negative factors that can impede a successful return to work for an individual who struggles with chronic pain and its mental and psychological sequelae. It is acknowledged in the industry that chronic pain is an expensive and anxiety-provoking problem for both individuals and organizations (Zinta 2006). In this regard, over the past three decades, researchers have identified several obstacles to successful and productive employment of workers affected by chronic pain and mental health. The following excerpt from a research article addresses this issue from both the perspective of environmental (employment setting) factors, as well as internal (cognitive capacity) considerations:

Low levels of support failed to generate favorable effects on the relationship between chronic pain and performance, which requires a brief explanation. First, at low levels of [perceived organizational support] messages regarding the organization’s intent may be viewed as malevolent rather than benevolent (Eisenberger, et al., 1986). Specifically, employees with chronic pain may see token attempts at assistance as solely beneficial to the organization with little perceived benefit to themselves (Levinson, 1965). Given their generally fragile emotional state (Iezzi, et al., 1999), those with chronic pain may react by distancing themselves from their supervisor and the organization under these conditions. Second, the cognitive obstacles that serve to confuse (and sometimes paralyze) chronic pain individuals are presumably not eliminated in low [perceived organizational support] environments. Hence, chronic pain employees may not be able to sufficiently complete the requirements of the job, leading to a further decline in effort. (Zinta 2006, p. 233).

What is more, studies on the differences between cultures, rates and levels of disability found that there is little, if any difference in reported levels of disability among countries, except for the manner in which disability is measured and reported. An important study comparing American and European disability levels explained that: (Banks, et al. 2005).

In this paper, we investigated the role of pain as a factor leading to work disability in three countries - The Netherlands, England, and the United States. In all three countries pain is by far the most important factor leading to reports of work disability. We also found however that respondents in these three countries who appear to be suffering from similar degrees of pain respond very differently to questions on work disability. These differences do not appear to be related to differential use of painkillers to alleviate the effects of pain or differential degrees of work accommodation available in the three countries.

Using a new methodology of vignettes which were implemented in Internet surveys in the United States and The Netherlands, our analysis claims that a significant part of the observed difference in reported work disability between the two countries is explained by the fact that residents of the two countries use different response scales in answering the standard questions on whether they have a work disability. Essentially for the same level of actual work disability, Dutch respondents have a lower response threshold in claiming disability than American respondents do. [p. 47]
In addition, a comprehensive study in Ireland found that for individuals who present with disabilities, returning to the workforce is no easy task: (Gannon and Nolan 2004).

To disentangle these inter-relationships systematically, regression techniques were applied to identify the influence of the presence of chronic illness or disability, and the extent to which it hampers or restricts the individual, on labour force participation. The results showed that those reporting a longstanding/chronic illness or disability which hampers them in their daily activities or restricts the kind of work they can do have a significantly reduced probability of labour force participation. For men who report being severely hampered or restricted that reduction is as much as 60 percentage points or more while, for women, it is about 50 percentage points. For those who report being hampered or restricted to some extent rather than severely the effect is much smaller but still substantial. On the other hand, for those reporting a longstanding/chronic illness or disability which did not hamper or restrict them, the probability of being in the labour force was similar to others of the same age, gender and educational attainment and not reporting any such condition. [p. 61]

It is clear from this and other citations that at least some chronic pain patients are restricted physically and psychologically to such a degree that they are unlikely to return to sustained, competitive employment, if they are fortunate enough to even procure a position. As such, when assessed based on the reality of the workplace, chronic pain patients are often unlikely to meet the demands of competitive employment and therefore, aside from their disability, face significant obstacles specific to the job market that preclude them from sustained, competitive employment positions.

Within Ontario and in fact Canadian common law, chronic pain has been universally accepted as a significantly disabling condition that can entitle claimants to benefits. In the case of Safi and Sovereign General, [2008] O.F.S.C.D. No. 7 (FSCO A04-001121, September 2007), the arbitrator held that:

Courts and FSCO arbitrators have recognized chronic pain syndrome, fibromyalgia, and other related medical conditions as significant medical impairments. [Koteyand State Farm Mutual Automobile Insurance Company (FSCO A97-001506, October 4, 1999); Martin v. Work-

The acceptance of chronic pain as a potentially significantly disabling medical condition is now indisputable: it was established by the highest court in the land, the Supreme Court of Canada, in the landmark decision of Martin v. Workers’ Compensation Board of Nova Scotia, [2003] 2 S.C.R. 504.

The key findings of that decision are summarized as follows:

[111] The challenged provisions of the Act and the FRP Regulations are rationally connected to this objective. There can be no doubt that, by excluding all claims connected to chronic pain from the purview of the Act and, in the case of workers injured after February 1, 1996, providing strictly limited benefits in the form of a four-week Functional Restoration Program, s. 10B of the Act and the FRP Regulations virtually eliminate the possibility of fraudulent claims based on chronic pain for all other types of benefits.

[112] The same reasoning, however, makes it patently obvious that the challenged provisions do not minimally impair the equality rights of chronic pain sufferers. On the contrary, one is tempted to say that they solve the potential problem of fraudulent claims by preemptively deeming all chronic pain claims to be fraudulent. Despite the fact that chronic pain may become sufficiently severe to produce genuine and long-lasting incapacity to work, the provisions make no effort whatsoever to determine who is genuinely unable to work and who is abusing the system. As the respondents correctly point out, the government is entitled to a degree of deference in its weighing of conflicting claims, complex scientific evidence and budgetary constraints, especially given the large unfunded liability of the Accident Fund. In other words, it is not sufficient that a judge, freed from all such constraints, could imagine a less restrictive alternative. Rather, s. 1 requires that the legislation limit the relevant Charter right “as little as is reasonably possible” (R. v. Edwards Books and Art Ltd., [1986] S.C.J. No. 70, [1986] 2 S.C.R. 713, at p. 772, per Dickson C.J.). However, even a brief examination of the possible alternatives, including the chronic pain regimes adopted in other provinces, clearly reveals that the wholesale exclusion of chronic pain cannot conceivably be considered a minimum impairment of the rights of injured workers suffering from this disability.
The general compensation scheme under the Act already provides that benefits may be limited, suspended or discontinued if the worker fails to mitigate losses, does not comply with medical advice, or fails to provide the Board with full and accurate information regarding his or her claim (ss. 84 and 113 of the Act). The adaptability of the system is illustrated by the approaches adopted by other provinces such as Alberta, British Columbia, Quebec and Ontario. These provinces all provide compensation for chronic pain within their respective workers’ compensation regimes, in some cases by adapting the assessment method to the reality of chronic pain so as to evaluate accurately each claimant’s level of impairment. This general approach is supported by considerable scientific evidence commissioned by the relevant workers’ compensation boards and introduced in evidence before this Court. See Chronic Pain Initiative: Report of the Chair of the Chronic Pain Panels (2000), which concludes that “[i]t would be difficult to support, on the basis of the existing scientific evidence, any limitation of benefits for chronic pain disability” (p. 5). Difficulties in establishing a causal link between a work-related injury and later development of chronic pain are also adequately handled within the scope of the general compensation system in these provinces: see Report of the Chair of the Chronic Pain Panels, supra; Dr. T.J. Murray, Chronic Pain (1995), prepared for the Workers’ Compensation Board of Nova Scotia, App. B; Association of Workers’ Compensation Boards of Canada, Compensating for Chronic Pain — 2000 (2000). In addition, courts faced with tort claims for chronic pain have also developed approaches that do not rely on blanket exclusion: see, e.g., White v. Slawter, [1996] N.S.J. No. 122, 149 N.S.R. (2d) 321 (C.A.); Marinelli v. Keigan, [1999] N.S.J. No. 23 173 N.S.R. (2d) 56 (C.A.). Even recognizing the Nova Scotia legislature’s constitutional entitlement to select from a range of acceptable policy options, it is impossible to conclude that the blanket exclusion it enacted was necessary to achieve a principled response to chronic pain and avoid fraudulent claims.

IRB (Pre-104 week) Case Law: Cognitive and Chronic Pain Considerations

In considering how chronic pain affects not only the ability to perform the physical, but also the cognitive demands of employment; and how this aspect is applicable in the context of the pre-104 week IRB disability test, we shall first look to Sivananthan and State Farm, [2004] O.F.S.C.D. No. 21 (FSCO A02-000307, February, 2004). In considering whether a female clerical worker with established chronic pain and cognitive difficulties documented in a vocational assessment and through collateral evidence, would meet the pre-104 week IRB test, Arbitrator A. Sone considered the following:

[The claimant] must prove that she suffered a substantial inability to perform the essential tasks of her employment. To decide whether she meets this test, I must determine what were the essential tasks of her employment. Based on the credible evidence I received from her, I find that the essential tasks of her employment at the time of the accident were clerical in nature. I find that they included the ability to work away from her residence and therefore included travel. I also find that they included the ability to arrive at work punctually and reliably, and to work full-time, for example, approximately eight hours per day, five days per week. (emphasis added) [p. 32]

In sum, to determine whether the claimant met the pre-104 week IRB test, while being cognizant of the claimant’s cognitive ability as compared to the cognitive work demands, the arbitrator considered the claimant’s:

- credibility
- productivity in a competitive work environment; and
- capacity to work full time.

There is a natural concern regarding the “invisible” disability resulting from chronic soft tissue pain. Where there is little or no objective evidence of
impairment, the claimant’s credibility becomes paramount. As noted by Arbitrator Sone, the claimant’s credibility can lead credence and objectivity to an otherwise strictly subjective condition:

Credibility. In significant measure, [her] complaints are subjective. Therefore, I must assess her credibility. In order to assess her credibility as a witness, I may evaluate her demeanor, internal inconsistencies in her evidence, contradiction by others, contradiction by documents, and the inherent implausibility of her evidence, given general knowledge of the human condition. If raised, I must also examine allegations of dishonesty or fraud. Sivananthan and State Farm, [2004] O.F.S.C.D. No. 21 (FSCO A02-000307, February, 2004).

Effectively, Arbitrator Sone is utilizing principles which are very consistent with those that psychologists would traditionally utilize in their own assessment of credibility. By way of comparison, the National Academy of Neuropsychology presents the following related concept in the context of “symptom validity”, which is defined as:

[T]he accuracy or truthfulness of the examinee’s behavioral presentation (signs), self-reported symptoms (including their cause and course), or performance on neuropsychological measures.

Essentially, the common element between the judicial and clinical approaches to addressing claimant credibility is that they both consider the consistency of claimant presentation. As postulated by the National Academy of Neuropsychology, the following are common methods for assessing symptom validity across studies, including with regard to:

3.1. Consistency

Consistency of information obtained from interviews, observations and/or test results can contribute to a determination of symptom validity. The following inconsistencies may indicate misrepresentation or fabrication of symptoms:

(a) self-reported history that is inconsistent with documented history
(b) self-reported symptoms that are inconsistent with known patterns of brain functioning
(c) self-reported symptoms that are inconsistent with behavioral observations
(d) self-reported symptoms that are inconsistent with information obtained from reliable collateral informants
(e) self-reported presence or absence of symptoms that are inconsistent with performance levels on psychometric tests

3.2. Performance on neurocognitive tests

(a) performance consistent with feigning on empirically derived indices obtained from scores of ability measures
(b) performance patterns on ability measures indicative of invalid responding
(c) inconsistencies between test results and known patterns of brain functioning
(d) inconsistencies between test results and observed behavior
(e) inconsistencies between test results and reliable collateral reports
(f) inconsistency between test results and documented background information


The assessment of pain is more complex than any of the other areas of disability, as the research clearly shows. While pain perception is a subjective experience, the impairment arising from the pain experience is not. In support of this notion, a group of American and Canadian researchers, (Coghill, et al. 2003) used psychophysical ratings to define pain sensitivity, as well as functional magnetic resonance imaging to assess brain activity. Their study identified that individuals reporting high sensitivity to pain, exhibited more frequent and more robust pain-induced activation of a number of areas in the brain (the primary somatosensory cortex, anterior cingulate cortex, and prefrontal cortex) when compared to individuals who claimed they were pain insensitive. As such, this research article identified objective neural correlates for the subjective differences in pain experience reported by pain patients. Therefore, the correlation between the subjective reports of pain magnitude and the objective findings on the neuro-imaging, lends validity to the assertion that subjective reporting of pain is an accurate description of the actual pain experience.

A more recent study revealed that,

“[c]hronic pain has a widespread impact on overall brain function, a finding that may offer a possible explanation for many of the common cognitive and behavioral...
comorbidities seen in such patients. Using functional magnetic resonance imaging (fMRI), investigators at Northwestern University, in Chicago, Illinois, found individuals with chronic back pain (CBP) had alterations in the functional connectivity of their cortical regions — areas of the brain that are unrelated to pain — compared with healthy controls.... This is the first clue we have that conditions such as depression, anxiety, sleep disturbances, and decision-making difficulties, which affect the quality of life of chronic pain patients as much as the pain itself, may be directly related to altered brain function as a result of chronic pain,” principal investigator Dante Cialho, MD, told Medscape Neurology & Neurosurgery, Feb. 2008.

The findings of these and related research studies again highlight the complexity of human experience and perception, and the need to rely on scientific data rather than the often inaccurate interpretations made by disability assessors, based on instruments that are not fully capable of measuring what they were designed to assess. Again, this discussion contributes to the argument that credibility of the chronic pain claimant is of utmost importance in the context of disability assessment. Thus, the question remains as to whether patients who, for a variety of reasons, are not the most credible, experience pain to a lesser degree, or whether they risk being discriminated against because of our inability to reliably measure underlying experienced pain in an objective manner.

Case Law Recognition of Non-CNS Cognitive Impairments and Consideration of “Work Engagement”

Judges and arbitrators have acknowledged the difficulty encountered by claimants experiencing occupationally disabling, but secondary cognitive impairments. Such recognition is vital in the context of ever increasing cognitive demands in the workplace. The cognitive barriers relative to these paramount work demands, are derived from at least one, and more commonly, the synergistic effects of MVA related major mood/anxiety disorders, chronic pain and/or sleep disorders. To this end, the arbitrators in Zach and State Farm, [2007] O.F.S.C.D. No. 134 (FSCO A05-002029, July 13, 2007) and Safi and Sovereign General, [2008] O.F.S.C.D. No. 7 (FSCO, September 2007, FSCO A04-001121) respectively stated that:

The weight of the psychological opinions and evidence presented leads me to conclude that the motor vehicle accident was a material or significant contributing factor in causing Mr. Safi’s depression, ongoing pain disorders, fibromyalgia, and chronic pain syndrome. I accept ... that on a psychological level, Mr. Safi currently experiences clinically significant difficulties in sustained attention, concentration, speed of information processing, and assimilating new information. He is psychologically substantially disabled from performing the essential tasks of any employment for which he might be reasonably qualified... I am therefore satisfied that Mr. Safi has suffered a substantial inability to perform the essential tasks of his job, and since the 104-week mark in November 2004, has suffered from a complete inability to engage in any employment for which he is reasonably suited by education, training or experience. Safi and Sovereign General (FSCO, September 2007, FSCO A04-001121) (p. 20)

And,

Ms. Zach’s evidence was that in November 2002 she had secured a higher paying job as a print manager with Barkley Printing – the expected start date was March 1, 2003. The job at Barkley was essentially the same type of job as the OAC with the position at Barkley requiring more driving and sales... Since the accident, Ms. Zach testified that she is able to sit up and do some work on the computer for approximately 2-3 hours at a time. After doing so, her head and eyes hurt and she often feels nauseous and then has to lie down and rest for several hours. She testified that she often requires an afternoon rest or nap. Ms. Zach consistently reported to several of her treating health practitioners that she has difficulty concentrating which has made it difficult to work in the area of graphic design. These symptoms and restrictions made it impossible for her to continue with her job at OAC or accept the position at Barkley Printing (p. 12).

I accepted Ms. Zach’s evidence that her head and eye pain resulted in her inability to concentrate and sit at a computer for more than a few hours at a time. Ms. Zach testified in a clear and forthright manner and I am persuaded, on a balance of probabilities, that she was not able to perform the essential tasks of her employment as a graphic artist from the termination date of her IRBs up to the 104 week point (p. 13) ... I find the evidence of Ms. Zach’s attempts at employment to be consistent with her evidence that she wanted to work and was not able to do so on a full-time basis. I view these attempts as a positive sign that she made an honest effort to earn a living and was trying to work within her limitations. However, given the reduced and flexible hours available at each of these jobs, I do not consider...
them to be evidence that she is employable on a regular basis. In addition, I find that part-time bus driving is substantially different in nature and status from her previous position as a graphic artist. Her education, skills and experience are in the area of graphic design...I am persuaded, on a balance of probabilities, based on the weight of the medical evidence and the testimony of Ms. Zach that she has been unable and continues to be completely unable to maintain continuing, competitive, productive employment for which she is reasonably suited by way of education, training or experience. *Zach and State Farm*, [2007] O.F.S.C.D. No. 134 (FSCO A05-002029, July 2007, p. 16; emphasis added to all quotations).

It is noteworthy that in the *Zach* case, there was no recognized MVA related psychological impairment noted to be contributing to her physical impairments as noted above.

An additional case which serves as a prime example of case law recognition that non-brain impairment based cognitive limitations are salient essential task barriers, may be found in *Z.T. v. Missisquoi Insurance*, [1997] O.I.C.D. No. 121 (FSCO OIC A96-000735, December 31, 1997), as follows:

Z.T. was a Product Assurance (P.A.) Project Manager at COM DEV between 1990 and 1992, responsible for ensuring the quality and reliability of its complex satellite programs. This required the planning, managing, implementing and monitoring of P.A. programs. A job description prepared concurrently with her employment indicated that the position (which required university education and management training) had important decision making responsibilities that directly contributed to the "financial, technical and schedule success of assigned projects" (including manpower allocation up to 20,000 hours per project), and required a “high degree of creativity, originality and self-reliance.” Z.T. had direct supervisory responsibility for up to six quality engineers, and indirect supervisory responsibility over other employees.

I accept that post accident Z.T. has suffered from pain, fatigue, depression, memory and concentration problems, and sleep disturbance. Using Dr. Faraawi’s analysis, considering her job demands, the nature of her illness, and her underlying personality, on a balance of probabilities, I find that Z.T.’s level of pain, discomfort, and depression has rendered her substantially unable to perform the stressful and demanding managerial position she held at COM DEV.

**Defining “Engagement” Relative to Essential Job Tasks**

The subsequent case law principles expounding upon the pre-104 IRB definition/interpretation, involve elaborations on the “engagement” aspect relative to the essential job tasks. In other words, the quality of the work activity that the individual is judged to be capable of performing, is considered in the context of the concepts of:

- productivity
- full-time work capacity
- consideration of work as an “integrated whole”.

Each of these concepts shall now be reviewed in relation to case law decisions. It should be noted that in Ontario case law, the principles depicted below are well engrained in the judicial/arbitral commentary and as such the quotations below are merely a select portrayal of those well established concepts.

**Productivity Criterion Reference**

In *Flemming and Wawanesa*, [1992] O.I.C.D. No. 12 (OIC A-000406, April 28, 1992), the capacity to work is considered in relation to the capacity to be productive:

... the fact that the Applicant is able to perform some functions of her occupation on a part-time basis does not address the standard of disability set out in the regulations ... In determining an applicant’s ability to perform his or her essential occupational tasks, the demands of such tasks cannot be evaluated in isolation from the broader employment context ... The performance of essential tasks must incorporate the ability to perform such tasks in a manner, at a speed, or for a time that renders such performance capable of being remunerative. (emphasis added) (p. 16)

**Full-time Criterion Reference**

*Soos and Canadian Surety* (OIC A97-001015, June 12, 1998) provides guidance with respect to the capacity to work full versus part-time hours. The arbitrator has no hesitation in holding that where the claimant had worked full-time hours prior to condi-
tion onset, the “focus of the inquiry must be on the applicant’s ability to perform the essential tasks of her job as opposed to whether or not certain tasks could be performed on a part-time basis”.

**Work as an Integrated Whole Criterion Reference**

Finally, addressing the common disability assessor pitfall of dealing only with the claimant’s capacity to perform discreet, segmented activities, the Arbitrator makes it abundantly clear that this is not acceptable:

It is not appropriate to simply identify a discrete series of employment competencies that an individual may be able to demonstrate under artificial testing situations and then to cobble these together into a theorized ability to engage in employment. This sort of analysis misses the whole dimension of employment being a living relationship between the employer and the employee. The Regulation talks about an ability to “engage in employment” not simply to perform discrete job tasks. In my view, to “engage in employment” is to participate actively in the work relationship over some reasonable period of time. In addition, the employee must be able to meet normal employer expectations. *Shubrook and Lombard*, [2004] O.F.S.C.D. No. 175 (FSCO A03-000361, November 26, 2004, at p. 10). (emphasis added).

**Pre-104 IRB Case Law Summary & the Case for Early Psychological Disability Documentation**

To summarize, the key principles of the case law which are paramount for clinical evaluators to follow in making pre-104 week IRB determinations, are as follows:

1. Essential job tasks must be clearly articulated on the basis of and derived from, at minimum a job description obtained from the claimant, but ideally on the basis of a comprehensive job demands analysis which considers the physical, cognitive, psychological, and interpersonal job demands.

2. Assuming that the claimant worked full-time prior to the MVA, his/her productive capacity must be considered in relation to full-time work demands.

3. The claimant’s productive capacity must be considered in relation to the quantity and quality of work that is commensurate with competitive employment.

4. The work activities under consideration must be considered as an integrated whole, and not individual, concrete job tasks.

5. Cognitive demands/impairments associated with the psychological and interpersonal demands of the occupation in question must be duly considered, evaluated and where possible, measured, similarly to the assessment of non-CNS demands/impairments.

The importance of early recognition, detection and measurement of psychologically derived impairments cannot be understated. Too often, treating psychologists will comment strictly upon treatment issues and will neglect to deal with occupational disability or other entitlement issues from the psychological perspective. Not only is it critical that frontline psychologists comment upon occupational disability, but it is vitally important that they express a clear opinion as to whether the psychologically based occupational disability is attributable to the subject MVA or other causal factor. The early detection and documentation of occupationally based psychological disability caused by the MVA increases the probability that future insurer disability assessments will be sufficiently comprehensive to include a diagnostic mental health assessment. Given the historical pre-eminence of physical impairments and related physical disability assessment procedures (such as the physical functional ability/capacity evaluation), insurers and IME assessors are understandably prone to underemphasize the psychological aspects, no matter how obvious these may seem based on the documented psychological diagnoses. Psychological impairments to consider in this vein include, but are not limited to:

- cognitive impairments (loss of sustained attention/concentration, impaired memory, information processing speed, cognitive persistence/stamina, reaction time, executive dysfunction, etc.)
• emotive impairments (amotivation, loss of behavioural control, stress intolerance, etc.)
• socio-interactive impairments (irritability, social withdrawal, loss of self-esteem/confidence undermining assertiveness, loss of empathetic capacity, etc.).

It is thus critical that the clinician specifically link the psychological impairment to the pertinent essential job tasks. As such, a loss of self-esteem and related social withdrawal in and of itself may have no bearing on a relatively socially isolated/independent occupation, whereas in roles in which social acumen and confidence are paramount, such as sales roles, these impairments, when significant, may certainly constitute an essential job task limitation.

In the next article (Part II) in this series, we shall review the case law definitions and interpretation of the Post 104-Week IRB Disability entitlement. In turn, the case law informs best practices and the requirement of careful consideration of a broad array of pivotal factors that ultimately determine whether or not a claimant meets the threshold for Post 104-week entitlement.

[Editor’s Note: Dr. J. Douglas Salmon, Jr. holds a Master’s degree in Vocational Rehabilitation Counseling and a Doctorate specializing in rehabilitation and neuropsychology and is the author and co-author of many rehabilitation assessment and outcome evaluation instruments, and treatment resource materials. Dr. Salmon served on several committees of the Financial Services Commission of Ontario addressing Designated Assessment Centre (DAC) development and consulted to the Minister of Finance’s DAC committee. Dr. Salmon’s multi-disciplinary clinics provide comprehensive rehabilitation services (<www.rtwintegratedhealth.com>) and multidisciplinary assessments (<www.synergyintegratedassessments.com>).

Dr. Jacques J. Gouws, C.Psych is a Psychologist in Clinical Practice and Consulting Psychologist at Human and System Interface Consulting Inc. in Guelph, Ontario. Dr. Gouws may be reached at <dr.gouws@nas.net> and 905-627-8204.

Corina Anghel Bachmann is a personal injury lawyer practicing with Bachmann Personal Injury Law, PC in Simcoe, Ontario and may be reached at <cbachmann@bachmannlaw.ca>.

References


Flemming and Wawanesa, OIC A-000406, April 28, 1992


Staff Report (2008), Chronic pain may harm the brain, Medscape Neurology & Neurosurgery, February 2008.

Statutory Accident Benefit Schedule – Accidents on or After November 1, 1996, Ontario Regulation 403/96, as amended by O. Reg. 35/10.


Current Events

Anna Okorokov

Events

April 25–28, 2016
Sparking Population Health Solutions: Research for a Healthier Future.
An International Summit
Ottawa, ON

May 4, 2016
IHPME Research Day 2016
Health Sciences Building
University of Toronto
Toronto, ON
May 6–7, 2016
The 6th Annual QuIPS Conference
Li Ka Shing Knowledge Institute
Toronto, ON

May 9–12, 2016
2016 CAHSPR Conference.
A Learning Healthcare System: Let the
Patient Revolution Begin!
Hilton Downtown, Toronto ON

May 13–14, 2016
2016 Canadian Conference on Physician Leadership
Royal York Hotel, Toronto, ON

May 26–27, 2016
Indigenous Health Conference
Hilton Meadowvale, Mississauga ON

May 30, 2016
National Forum on Simulation for Quality & Safety
Sheraton Gateway Hotel, Toronto Pearson
International Airport, Terminal 3, Toronto ON

June 5–8, 2016
e-Health 2016, Reimagining Healthcare Delivery in Canada
Vancouver Convention Centre, Vancouver BC

June 7–8, 2016
Transforming Canadian Healthcare through Innovation
The Arcadian Court, Toronto ON

June 13–16, 2016
Public Health 2016
Sheraton Centre Toronto Hotel, Toronto ON

October 2–5, 2016
Law Enforcement and Public Health Conference
Amsterdam, Netherlands

October 3–5, 2016
Optimizing the Canadian Health Workforce
Shaw Centre, Ottawa ON

November 14–18, 2016
Fourth Global Symposium on Health Systems Research
Vancouver Convention Centre, Vancouver BC

Movers & Shakers

Professor William Lahey, past director of the Health Law Institute and former senior public servant, has been appointed next President and Vice-Chancellor of the University of King’s College, Halifax.

Carrot Rewards, Canada’s first wellness rewards program was launched in March 2016 by Kamal Khera, Parliamentary Secretary to the Minister of Health, Terry Lake, Minister of Health for British Columbia, and Andreas Souvaliotis, Founder and CEO of Social Change Rewards.

Dr. Graham Collingridge was awarded the Brain Prize by the Grete Lundbeck European Brain Research Foundation in Denmark, for his research into the mechanisms of memory. Dr. Collingridge is a Senior Investigator at the Lunenfeld-Tanenbaum Research Institute, part of Sinai Health System, and Chair of the Department of Physiology at the University of Toronto.

Dr. Karel terBrugge has retired from his role as Head of the Division of Neuroradiology and Site Chief of Medical Imaging at Toronto Western Hospital. Dr. terBrugge continues to teach and train neurointerventional therapists around the world.

Trillium Health Partners was awarded the 2015 Booth Centennial Green Award for its commitment to sustainability.

The BC Centre for Excellence in HIV/AIDS (BC-CfE), in collaboration with Vancouver Coastal Health (VCH), has created a first-of-its-kind system for identifying HIV transmission outbreaks in near real-time.

[Editor’s note: Anna Okorokov, BA (Hons), LLB, completed her articles at a boutique civil litigation firm and was called to the Ontario bar in September. Anna is Managing Editor – Current Affairs for Health Law in Canada and can be contacted at <anna.okorokov@gmail.com>.]