Welcome readers to the Summer edition of Health Law in Canada.

As mentioned in the last edition, health care reform is ‘all the talk’ these days. As I write this foreword, all Canadian provincial and territorial premiers are in Whitehorse, Yukon this week discussing health care transfers, among other issues. The issue is whether the federal government will provide more financial transfers to the provinces for the delivery of health care services. The matter has become particularly relevant because a guaranteed annual transfer growth of six per cent is ending next year. This means that instead of continuing at six per cent, transfers are scheduled to increase in line with the rate of economic growth and the guaranteed increase will drop to three per cent.¹

At the same time, Federal Health Minister, Jane Philpott, has been leading the discussions with the provinces on a new health accord. Premiers are hopeful that the federal government will announce a transfer increase as part of these negotiations with the provinces. The issue is not clear cut, as some provinces have requested the federal transfer formula to take into account demographics (for example, the elderly or other vulnerable populations).

Ultimately, any funds received by each province will need to be implemented in line with provincial and territorial health care policy and within the province’s legal framework. With the federal and
provincial governments discussing the details regarding a new health accord, *Health Law in Canada* in partnership with the Institute for Health Policy, Management and Evaluation, University of Toronto has decided to hold a conference on September 14, 2016 in Toronto, Ontario on health care reform. Our conference entitled, “A Roundtable on the Canada Health Act: Version 2.0” is focused on the Canada Health Act because it forms the basis for any discussions on health care reform and, of course, is the backbone for our current health care system. The principles enshrined in the *Canada Health Act* specify the criteria with which provincial and territorial health insurance programs must conform, in order to receive federal transfer payments under the Canada Health Transfer regime. These federal transfer payments are exactly what the provinces are negotiating with the federal government. Any discussion about health care reform must begin, or at the very least address, the Canada Health Act. Our conference is timely for this reason. The goals 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 is affected.

We hope that readers will take the time to read the articles included in this edition — all focused on the issue health reform. Our next issue of *Health Law in Canada* will be a special double edition focused on the articles submitted by conference participants and attendees.

[Editor’s note: Content for the Editorial on Health Care Reform in the May issue of *Health Law in Canada* came from the following two sources:

“Fear and loathing stalk healthcare reform: Hepburn” *The Toronto Star* (27 March 2016)

“Philpott wants new Health Accord in place by 2017, a ‘fundamental change’” *The Hill Times* (15 March 2016)]

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Threatened Litigation Returns Abortion Access to Prince Edward Island after 34 Years
Nasha Nijhawan & Kelly McMillan

Abstract

On March 31, 2016, the government of Prince Edward Island committed to provide medical and surgical abortions in a public health facility in the Province by the end of the year, for the first time since 1982. The Province’s announcement was a direct response to threatened Charter litigation initiated by a group of local veteran activists called Abortion Access Now PEI Inc., which challenged the government’s policy not to provide abortion services in the Province. In this commentary, legal counsel for Abortion Access Now PEI Inc. situate the recent litigation efforts within the history of abortion access and advocacy in PEI. They attribute the reversal of the government’s position to the successful reframing of the Province’s abortion policy in the threatened litigation and the sustained and creative approaches employed by abortion access activists.

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1 Bill Curry, “Trudeau’s smooth provincial relations face first test over health care” *The Globe and Mail* (18 July 2016).
On March 31, 2016, the Premier of Prince Edward Island, Wade MacLauchlan, announced that by the end of 2016, the Province will develop a plan to open a women’s reproductive health clinic in an Island hospital, which will offer both medical and surgical abortion.¹

This announcement represented a sudden reversal in the Province’s 28-year-old policy not to provide abortions on the Island. As recently as December 28, 2015, Premier MacLauchlan stood staunchly by the “status quo” of sending women off of the Island to obtain abortion services, citing the divided views of Islanders as the basis for the Province’s abortion policy.²

Following the Province’s policy reversal, the question on everyone’s lips was: “why now?” As Premier MacLauchlan candidly admitted, his decision was a concession to threatened litigation pursuant to the Canadian Charter of Rights and Freedoms,³ which was served on the Province on January 5, 2016 by a group of veteran advocates called Abortion Access Now PEI Inc. (“Abortion Access Now PEI”).⁴ The Premier’s surprising announcement came only four days before the lawsuit was scheduled to be filed with the Supreme Court of Prince Edward Island (after the 90-day notice period required under the PEI Crown Proceedings Act)⁵ — eliminating the need for potentially costly and protracted litigation.

As social movements rarely score their victories by merely threatening Charter litigation, the question of why it worked in this case is one that bears further comment. In our view as counsel for Abortion Access Now PEI, the recent success can be attributed to the way the litigation fundamentally reframed the discussion about what the Province was doing and why they were doing it, against a backdrop of strong, sustained, creative activism by abortion access advocates on PEI. In this commentary, we situate the recent litigation within the history of abortion access on PEI and a larger advocacy project, of which litigation was simply one part.

Defining the “Abortion Policy”: History of Abortion Access on Prince Edward Island

Naming and defining the Province’s abortion policy became the foundational question for us, as counsel for Abortion Access Now PEI, in determining how litigation could be used to challenge what had become referred to as the “status quo”.⁶

Before Abortion Access Now PEI’s threatened litigation, activists and health providers alike had difficulty identifying the Province’s exact policy with respect to abortion. In 2011, the CEO of Health PEI, Dr. Richard Wedge, stated publicly that no regulatory barriers to abortion existed, and that any physician who wished to perform the procedure on PEI could do so freely.⁷

This position was debunked, however, when, in 2014, a working group at the Queen Elizabeth Hospital in Charlottetown tried to develop a plan to bring a Nova Scotia physician to the Island on a monthly basis to provide abortion services. The proposal was approved by a Provincial Medical Advisory Committee, but before it could be considered by the Executive Leadership Team of Health PEI, the Province instructed Health PEI to cease all work on the proposal because it was “against government policy” — much to the surprise of the then CEO of Health PEI.⁹ Despite being cited as the basis for quashing the proposal, the exact policy itself remained unstated and unclear.

Pinning down the Province’s “policy” was thus the first order of business in preparing the legal case. Through detailed research and dozens of freedom of information requests, Abortion Access Now PEI was able to define the Province’s “Abortion Policy” as including a decades-old legislative resolution not to provide abortion services on the Island, implemented through administrative and regulatory barriers and continued efforts to maintain the status quo by quashing proposals for change.
Research revealed that on March 30, 1988, the Legislature of Prince Edward Island passed a non-binding resolution setting out its moral and policy position on abortion services in the province. Although no abortions had been performed in the province since 1982, “Resolution 17” was a reaction to the 1988 decriminalization of abortion by the Supreme Court of Canada in *R. v. Morgentaler*. Resolution 17 stated that PEI “oppose[s] the performing of abortions” except to save the life of the mother. This position was attributed to “the political will to protect the unborn fetus”.

Parliament never legislated following the decision in *R. v. Morgentaler*, and no change came to PEI. Consistent with Resolution 17, abortion services remained unavailable in Island hospitals.

Attempts by Dr. Henry Morgentaler in the early 1990s to challenge the Abortion Policy were met with a redoubling of the government’s obstructive efforts. In 1993, the Province created a regulation to restrict payment for abortions to procedures performed in a hospital and pre-approved as “medically necessary” by a committee of doctors appointed by the Minister of Health. While Dr. Morgentaler challenged the regulation successfully in the Supreme Court of Prince Edward Island, that decision was overturned by the Court of Appeal, which upheld the regulation as duly authorized by its enabling statute.

Dr. Morgentaler never opened a private clinic in PEI. Over the years, however, many Island women traveled to Morgentaler clinics in Fredericton or Montreal, where they paid approximately $750 out-of-pocket for the procedure, in addition to the expense of travel and accommodation.

In 1995, the Province entered into an arrangement with a hospital in Halifax to enable PEI women to receive abortions there. This arrangement was codified in a Health PEI policy effective April 1, 1995, entitled “Criteria for Payment of Approved Therapeutic Abortions”. While the Province covered the cost of the procedure under this arrangement, women had to organize and pay for their own travel and accommodations. They also faced delay and barriers to obtaining necessary testing and referrals, in addition to the hardship of leaving their home province.

Women who could not travel off-Island because they lacked the financial means or transportation, had other family obligations, or lacked independence because of age, family violence or a myriad of other vulnerabilities simply could not get an abortion.

Despite the existence of the Halifax arrangement since 1995, the Province did not provide any information about how PEI women could access this service, and misinformation was rampant. The Halifax arrangement was not made available on the Health PEI website until 2014, and was not included in or appended to any other relevant policy or agreement regarding the provision or payment of health services. (Abortion Access Now PEI only obtained it through an FOI request.)

The Province was able to rely in part on the lack of clarity around the Abortion Policy to maintain the status quo for decades. Maintaining this status quo became the unwritten policy.

In its draft court application served on the Province on January 5, 2016, Abortion Access Now PEI was able to distill this lengthy history into discernible, deliberate state action. The application defined the “Abortion Policy” as a policy since 1988 “not to provide abortion services on-Island”. Abortion Access Now PEI then identified the steps taken by the Province to implement the Abortion Policy over the years, including:

- A regulatory requirement that abortions be pre-approved by at least one PEI physician before they are funded by the Province (the “pre-approval requirement”); and
b A regulatory requirement that abortions be provided in hospitals in order to be funded by the Province (the “hospital requirement”);

c The ongoing exercise of the Minister’s discretion or authority under the Health Services Act and the Health Services Payment Act to obstruct the provision of abortions in hospitals in PEI.

By identifying positive government action in the form of regulatory barriers and Ministerial decision-making, Abortion Access Now PEI directly contradicted the government’s established narrative that no regulatory obstacles in fact existed — and set the stage for the legal challenge.

**PEI women begin to speak out**

There is no question that, on PEI as elsewhere, “abortion is a stigmatized medical procedure”.15 Women who seek abortion are subject to “perhaps the clearest instance of stigmatizing reproductive health treatment”.16

This was particularly the case on Prince Edward Island, where abortion was shrouded in stigma, shame and discriminatory stereotypes about women’s reproductive autonomy. Indeed, the Abortion Policy of the government of Prince Edward Island reinforced and perpetuated this pre-existing stigma and shame.

The tide turned when PEI women began to compile personal stories of how the Abortion Policy had caused harm and impacted their dignity, and raised a collective voice to speak about their experiences. Though passionate advocates for access to abortion had been active on the Island for decades, their tone and tactics changed.

In January 2014, Dr. Colleen MacQuarrie published a study out of UPEI detailing the experiences of women who tried to access abortion services, illustrating the impact of the Abortion Policy on women’s physical, mental and emotional health.17 Shortly thereafter, a website called The Sovereign Uterus published a collection of first-person accounts of the Abortion Policy’s impact, using art and social media to promote the issue.18

Abortion access was an election issue in PEI in 2015. However, no candidate promised to repatriate care to the Island.19 The best that soon-to-be Liberal Premier, Wade MacLauchlan, promised was better access out of the Province.

On June 2, 2015, the newly elected Premier announced that PEI women would be able to access abortion services in a hospital in Moncton, in addition to the hospital services available in Halifax since 1995. This, he said at the time, fulfilled the government’s obligation “to be in line with the Charter of Rights and Freedoms”.20 With the option of self-referral, the Moncton option improved upon the access available in Halifax and represented the greatest advance in abortion access on PEI in 20 years. However, travel and cost barriers (still prohibitive for many women) remained intact, as did the powerful stigma around abortion in PEI.

While the Province claimed to be meeting its Charter obligations, abortion access advocates did not agree.

**The “Abortion Litigation”: Abortion Access Now PEI’s Charter Challenge**

For abortion access advocates on PEI, litigation was a last-ditch option, and only one strategy within a larger advocacy project. The members of Abortion Access Now PEI were mindful that the courts likely could only offer a declaration that the Abortion Policy was unlawful, but would not be able to impose a positive obligation on government to provide the service.

Abortion Access Now PEI’s threatened legal challenge was ultimately successful, in our view, because it was able to take the experiences of PEI women and frame them in terms the government could not dismiss. It had always been clear to advocates for access to abortion that the Province’s
Abortion Policy perpetuated stigma and discriminatory stereotypes about reproductive autonomy, caused significant psychological and physical harm (including delay), imposed financial costs on women, and prevented the most vulnerable Islanders from accessing an essential medical service altogether. Expressing those harms through activism alone, however, had not proved successful in forcing the government to repatriate care.

Once the abortion policy was identified, named, and framed in terms of positive government action, however, Abortion Access Now PEI was well-positioned to attack the Abortion Policy on administrative law and Charter grounds. The litigation changed the discussion, and framed the problem in a way that the Province could not ignore (or, as it turned out, dispute).

The proposed litigation adopted a dual administrative law and Charter rights approach, and is described in more detail below.

A. Administrative Law Challenge
Abortion Access Now PEI argued, first, that sending abortion services off-Island contravened the government’s own health care standards, contained in the Provincial Health Plan, and was therefore ultra vires the Minister’s authority under the Health Services Payment Act and the Health Services Act.

A fundamental principle of Canadian administrative law is that all state action must find its source in legislation. Abortion Access Now PEI relied on this principle to argue that PEI’s Minister of Health was acting outside of the scope of his authority by failing to “ensure the provision of health services in the province in accordance with the provincial health plan”, as required by s. 2(2) of the Health Services Act.\(^21\)

In particular, by continuing to implement the Policy that abortions would not be provided on-Island, the Minister was contravening the Provincial Health Plan, which provided that general and gynecological surgery and obstetrical services would be provided at the Queen Elizabeth Hospital in Charlottetown and the Prince County Hospital in Summerside.\(^22\) At the same time, medical procedures comparable to abortion were provided in Island hospitals, such as dilation and curettage (“D&C”), which was performed in Charlottetown under billing code 6009, between 50 and 80 times per year.\(^23\)

By continuing to refer women off-Island for surgical abortions, the Minister was also failing to ensure compliance with the Provincial Health Plan. The plan provided that only “highly specialized in-patient and out-patient treatments, procedures and consultations” would be provided out of province, such as “neurosurgery, brain injuries, specialized cancer treatment, specialized psychiatric treatment, and specialized children’s treatments”.\(^24\) Abortion, by contrast, is a non-specialized procedure, and can be performed safely outside of a hospital by a primary care physician.\(^25\)

The Province’s Abortion Policy was simply not supported by its own published health care standards.

B. Challenge under the Canadian Charter of Rights and Freedoms
More significantly, perhaps, Abortion Access Now PEI argued that the Abortion Policy violated a number of rights of Island women under the Canadian Charter of Rights and Freedoms. From the perspective of PEI activists, casting on-Island a cess to abortion as a Charter rights issue was essential to capturing and affirming the lived experience of Island women under the Policy over nearly three decades.

(i) Section 15: Equality Rights
Abortion Access Now PEI relied heavily on the equality guarantee at s. 15 of the Charter, arguing that the Abortion Policy discriminated on the basis of sex by treating abortion — a procedure only required by persons who become pregnant — in a
manner that is different from the way the Province treated comparable basic health services.\(^{26}\)

When the Abortion Policy was situated in the historical context described earlier in this paper, it became clear that even the purpose of the policy was discriminatory. The primary objective of the Policy — as expressed in Resolution 17, for instance — was to restrict women’s access to abortion on the basis that abortion is a socially undesirable or immoral practice. Such policy rationales are simply no longer permissible under the Charter.\(^{27}\)

The Abortion Policy also had discriminatory effects. By expressing disapproval for abortion and those who obtain it, the policy perpetuated the stigma associated with the procedure. It also effectively restricted women’s access to abortion, denying them the freedom to make decisions about their own health and body. In doing so, it reinforced stereotypical assumptions that the state was better equipped to make decisions about individuals’ reproduction and parenting. The Abortion Policy therefore undermined the values of personal autonomy and self-determination that the Supreme Court has recognized underpins the equality guarantee.\(^{28}\) Indeed, the Policy seemed to fly in the face of the sentiments expressed by Justice Wilson, concurring in \textit{R v. Morgentaler} more than 25 years ago, that:

\begin{quote}
The right to reproduce or not to reproduce which is in issue in this case is … properly perceived as an integral part of modern woman’s struggle to assert her dignity and worth as a human being.\(^{29}\)
\end{quote}

Even for women who were able to access abortion, the Province’s Policy still imposed disproportionate burdens by requiring the women to travel outside of their province to access abortion — a requirement not imposed on any other group in respect of comparable health services.

(ii) \textbf{Section 7: Security of the Person and Liberty}

In addition to making arguments under s. 15, Abortion Access Now PEI also advanced a claim under s. 7 of the Charter, alleging that the Province’s Policy deprived residents of the right to liberty and security of the person in a manner that did not accord with the principles of fundamental justice. Our interviews with Island women and abortion rights advocates revealed that the policy increased risks to women’s health in a number of ways. For instance:

- delays in accessing the procedure can lead to a need for more invasive techniques;
- barriers to access drove women to seek riskier alternative options;
- health care providers were deterred from providing safe abortions or post-abortion care;
- women unable to access abortion carried unwanted pregnancies to term; and
- women experienced psychological harm caused by the stress and uncertainty of limited access to abortion.

Many of these harms were recognized as depriving women of their security of the person by the Supreme Court of Canada in \textit{R v. Morgentaler}.

Abortion Access Now PEI further claimed that the Abortion Policy deprived women of their liberty contrary to s. 7 of the Charter, by removing reproductive decision-making power from individual women and placing it with the state. Nearly 30 years ago, Justice Wilson concluded in her concurring opinion in \textit{R. v. Morgentaler} that “the right to liberty contained in s. 7 guarantees to every individual a degree of personal autonomy over important decisions intimately affecting their private lives”, and identified “the decision of a woman to terminate her pregnancy” as “fall[ing] within this class of protected decisions”.\(^{30}\) PEI’s Health Services Payment Regulations, however, required Ministerial pre-approval as a condition for payment for an abortion.\(^{31}\) From the perspective of Abortion
Access Now PEI, there was no question that this requirement was inconsistent with the right to liberty at s. 7 of the Charter.

Abortion Access Now PEI submitted that the deprivations caused by the Abortion Policy were inconsistent with the principles of fundamental justice. The policy was arbitrary, in that it was not rationally connected to any valid governmental objective, such as cost savings, or the objectives of quality, equity, efficiency or sustainability outlined in PEI’s provincial health plan. The Abortion Policy also harmed women in a manner that was grossly disproportionate to any health systems or moral objective.

(iii) Section 12: Cruel and Unusual Treatment

Finally, Abortion Access Now PEI advanced a novel claim under s. 12 of the Charter, alleging that, in some cases, the impact of PEI’s Abortion Policy rose to the level of cruel and unusual treatment by the state. Abortion Access Now PEI alleged that PEI residents are within the “administrative control of the state” with respect to their ability to access local health care services, thereby engaging s. 12 of the Charter. By continuing to implement the Abortion Policy — including through regulatory barriers — the Province was engaged in a pattern of conduct to ensure that no abortions were made available in PEI, in order to advance a particular concept of morality. This pattern of conduct targeted women, with cruel indifference to its disproportionate effects, including: limited, uncertain or delayed access to abortions; recourse to risky alternative treatments; disproportionate impact on young women; and chilling effects on health care providers, leading to substandard care in some cases; as well as hardships associated with travel. This state treatment, according to Abortion Access Now PEI, was arbitrary and degrading to human dignity and worth.

Developments during the 90-day Notice Period

During the 90-day notice period, public pressure on government was sustained through a social media and guerrilla art campaign by “Shirley Karats” (an artist pseudonym with a nod to the Island’s most beloved fictional daughter). The Premier was also directly targeted with the hashtag #HeyWade, and a reference to his own campaign slogan, #ItsTime — and a six-foot handwritten letter left outside his government office.

By the time the Premier made his surprise announcement, advocates had all but given up hope that the matter would be resolved by a government concession. They were gearing up for a long and acrimonious court battle, preparing to voice their stories in the courtroom.

Why did the government concede?

In his remarks to the media on March 31, 2016, Premier MacLauchlan attributed his decision to repatriate abortion services to his conclusion that the Province could not successfully defend the policy under the Charter. Citing legal advice, he said that “the current policy would likely be found to be contrary to equality rights guaranteed under the Canadian Charter of Rights and Freedoms as well as Charter guarantees of security of the person”.

While thrilled, we were also astonished to hear the Premier acknowledge both the existence of the “Policy” as well as the human rights violations identified in the case as the basis of the government’s policy reversal. In the end, it is clear that the threatened litigation provided the Province with both a motivation and an excuse to do the right thing. By reframing on-Island access to abortion as a Charter issue, Abortion Access Now PEI was able to properly place responsibility for the harm caused by the status quo on the government’s own actions. Once placed there, the government had to face its obligations to Island women.
The true activism remains in the tireless advocacy of our clients and of those who have spoken out ceaselessly to bring change, even in the face of shame and stigma and at great personal cost. The personal stories shared through Dr. MacQuarrie’s research, and in spaces like The Sovereign Uterus intended to “shatter stigma, raise awareness and break the silence around abortion on PEI”, and in public demonstrations and speak-outs, made a long-standing issue increasingly difficult for the Province — and the rest of the country — to ignore. We are proud that we were able to translate the voices of PEI women into the language of law, which remains, for better or worse, the language of power. Representing them at this critical moment in the movement was our privilege: the stuff a lawyer’s dreams are made of.


You can find more information about their work at <www.nmbarristers.com> or follow them on Twitter @nmbarristers]

1 In this paper, we use the terms “abortion” or “surgical abortion” to refer to the voluntary or elective termination of a pregnancy by surgical intervention. “Medical abortion” refers to a termination of pregnancy by non-surgical means, using a drug such as mifepristone.


8 “No need for local abortion services, says province” CBC News (26 May 2014) online: <http://www.cbc.ca/news/canada/prince-edward-island/no-need-for-local-abortion-services-says-province-1.2654757>.

9 Ibid.


11 “Resolution 17” reads:

WHEREAS the Parliament of Canada must now legislate a new law concerning abortion;

AND WHEREAS the great majority of the people of Prince Edward Island believe that life begins at conception and any policy that permits abortion is unacceptable except to save the life of the mother;

AND WHEREAS the great majority of Islanders demand that their elected officials show leadership on this very important issue and demonstrate the political will to protect the unborn fetus;

THEREFORE BE IT RESOLVED that the Legislative Assembly of Prince Edward Island oppose the performing of abortions;

AND BE IT FURTHER RESOLVED that this Resolution be forwarded to the Leaders of all three federal political parties requesting the passage of legislation consistent with the intent of this Resolution.

12 Health Services Payment Act Regulations, P.E.I. Reg. EC499/13, ss. 1(c)(iv), 6(1)(c).

PART II: Case Law, Best Practice and the Post-104 Week IRB Disability Test

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

Abstract

The following is Part II of a three-part paper presenting holistic models of determining impairment and occupational disability with respect to common “own occupation” and “any occupation” definitions, especially in the motor vehicle accident (MVA) context. This segment of the paper is for the purpose of educating readers regarding pertinent case law and related evolving judicial/arbitral interpretations surrounding the Post 104-week income replacement entitlement within the Ontario MVA insurance system. Best practices in disability assessment methodology and analysis are supported in the context of holistic occupational disability assessment models in relation to the relevant case law. Comparative analysis was also utilized to inform the reader of the emphasis upon the quality of activity engagement across pre- and post-104 week spheres. Beyond the MVA sphere, medically-legally, the reviewed case law and related clinical best practices are fully germane to the long term disability and WSIB (workers’ compensation) sectors.

14 This policy was last revised in July 2013. Revisions of the policy dated July 1995, July 2001, July 2007 and July 2013 are on file with the authors.


20 Canadian Press, “Moncton Hospital to offer abortion services for PEI women” CTV News (2 June 2015), online: <http://atlantic.ctvnews.ca/moncton-hospital-to-offer-abortion-services-for-p-e-i-women-1.2402536>.


22 Department of Health and Wellness, Provincial Health Plan (July 2010) at 3, 7 (on file with the authors) [Plan].

23 Response to FOI #1690-20-28 14 (14 January 2015) (on file with the authors).

24 Plan, supra, note 22, at 31.


31 Health Services Payment Act Regulations, P.E.I. Reg. EC499/13, ss. 1(c)(iv), 6(1)(c).


33 See “Shirley Karats”, online: <https://twitter.com/iamkarats>.

A specific area emphasized by authors is that the assessment of pain is more complex than is generally acknowledged in many disability assessments. Research on the impact of pain on individuals with disabilities and impairments arising from injuries sustained, clearly demonstrates that traditional pain measurements are often inadequate to fully determine the disability arising from pain. Finally, particularly in the context of Insurance Examinations (IEs and Independent Medical Assessments for LTD), the principle of competitive employability is often not considered as it should be in accordance with the existing case law.

Part I of this three-part series reviewed the case law and clinical best practices relative to the pre-104 week income replacement benefit (IRB) entitlement. In parallel fashion, this paper reviews similar aspects relative to the post-104 week IRB test. Once again, presentation of “clinical best practices” shall be derived predominantly in the medical-legal context, i.e., as clinical practice methods that are best suited to addressing related case law directives which ultimately define the meaning of the post-104 entitlement. It is otherwise assumed that clinicians are using best practice clinical methodology relative to their own professional guidelines and requirements.

**Post-104 Week IRB Disability Test**

As will be recalled from the first paper in the series, the initial or pre-104 week IRB disability test is 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.

The inaugural paper presented the related case law which served to deconstruct the above definition, thus providing evaluators with a clear road map as to how to appropriately interpret the test and address it using case law guided best practices.

In moving on to the longer term IRB disability threshold, the following disability test applies:

> 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.

Across jurisdictions, this eligibility criterion is commonly used in long-term disability benefits as well as the Ontario MVA sector. Figure 3 below is a schema which is analogous to the pre-104 week IRB schema shown in Part I. Once again, the primary injury/illness gives rise to a unique constellation of physical, emotional and cognitive impairments. In this phase however, because there is no specifically targeted occupation with unique related demands, there is no role for comprehensive on-site job demands analyses *per se*. Rather, the first step is that of identifying a cluster of occupations that may potentially suit the claimant by “education, training or experience”. The primary driver of such a quest is that of the combined inputs of the general functional ability/capacity evaluation (FAE) and the psychovocational assessment. The general FAE may occur in the context of a multidisciplinary disability assessment, or it may exist on file in advance of the disability assessment.

The psychovocational assessment serves to identify the “personal and vocational” characteristics of the claimant. It is similar in format/methodology to the rehabilitation-oriented psychovocational assessment, but is distinctly different from its rehab cousin in focus and orientation. In a rehabilitation context, the psychovocational assessment serves as the first step in the identification of actual vocational rehabilitation objectives of the patient/client within the purview of his or her residual physical, cognitive and psychological abilities. As such, it will be the springboard towards plotting a specific course of occupational training, skills enhancement, and/or direct placement.

The post-104 IRB psychovocational assessment on the other hand, may never be used for voca-
tional rehabilitation planning purposes. In this respect, regardless of some overlap, it is specifically a disability determination tool. As such, while maximizing the claimant’s vocational interest, motivation, and personal values and lifestyle objectives is a consideration, these factors are appropriately downplayed in the interest of identifying a broader array of occupations which serve to mitigate the claimant’s financial losses.

This does not mean that one ought to completely ignore a claimant’s vocational interests. Constraints are placed on job selection by the requirement to consider the impact of such occupational choices upon the claimant’s overall well-being and in recognition of his or her past job history, particularly wherein he or she has intentionally moved out of a prior line of work.

**Figure 3. Post-104 week “any occupation” disability determination.**

Applying the Venn diagram concept of essential job tasks (Figure 1) to the post-104 week IRB test, essentially the same criteria are used, but replicated across all occupations under consideration. Ultimately, those occupations for which there is a clear correspondence between substantial impairments and substantial job tasks, are ruled out, while those circumventing the claimant’s substantial impairments are ruled in.

**The Work Environment/Demands: National Occupation Classification**

The National Occupational Classification (NOC) is the taxonomy for occupational classification in Canada. As there are no pre-determined occupations one must consider in order to determine whether a claimant meets the post-104 week IRB test, there must be a methodology to consider the work demands/environment in the search for those suited to the claimant by education, training or experience. The NOC classifies occupations by skill levels (first digit), skill type (second digit),
minor groups (third digit), and unit groups (fourth digit). Each occupation is coded in terms of the following workplace characteristics and required qualifications:

- aptitudes related to the occupation
- interest factors common to those who work in the occupation
- worker functions (data, people, things)
- physical activities required
- environmental conditions
- education/training requirements.

Once the above occupational demands and environmental factors are established, a claimant’s corresponding characteristics can be compared to the occupational profile. In other words, the work activity demands and related factors are then compared to the claimant’s residual ability-based productive capacity and to any potential disability specific contraindications (e.g., temperature extremes in relation to chronic pain).

In considering occupational cognitive, psychological and interpersonal demands as articulated above, the disadvantage of the NOC is that more refined demands in these specific domains cannot be well identified and systematically considered in the analysis. The NOC remains a generally good guide however, and on the basis of “average” demands/characteristics within an occupational group, these concerns are dampened to some degree.

The Case Against Computerized Transferable Skills Analyses

To the inexperienced eye, the need to formally measure a claimant’s ability to engage in suitable occupations may not be obvious in the context of the “education, training or experience” mandate. Can’t one simply look at each of these factors and derive an occupational profile based upon the claimant’s past job experience? This is the very approach utilized in Computerized Transferable Skills Analysis (TSA). TSAs basically review the subject’s past job history, and on the basis of the associated NOC profiles for each occupation, generate a representative aptitude profile on the basis of the highest “demonstrated” aptitude levels across all of the previous occupations combined. This conjectured aptitude profile, based upon a supposedly proven “pre-condition” occupational history, is however flawed in many ways. Transferable skills are based on “aptitudes” which reflect a person’s potential to learn a skill and are NOT synonymous with actual skills acquisition. For example, an individual may have the aptitude to be a carpenter’s assistant, but that doesn’t mean the person actually has functional work skills in this area (and often they do not). By contrast, a comprehensive psychovocational assessment ideally includes a “functional transferable skills analysis” to determine actual skills that the individual has acquired over their career, rather than merely considering his or her skills potential. Even if the computer-generated profile appropriately reflects the claimant’s premorbid aptitude levels, if a claimant remains symptomatic and impaired at the two-year point post accident, there is a very low likelihood that the premorbid measured aptitude levels will be maintained at that time because:

1. Pain, emotional, and cognitive impairments will typically erode functioning such that the individual will not be able to perform many of the suggested computerized TSA jobs (psychovocational/neurovocational evaluation would show that they are performing well below acceptable levels).

2. Reported levels of premorbid education and academic skills are commonly undermined by disuse of these skills pre-accident; further erosion occurs post accident due to even more pronounced and prolonged disuse and cognitive impairments.

3. Foreign education in non-English generally results in testing scores well below English-based equivalency.
4. People often obtain jobs (pre-accident) through friends and family, thereby bypassing the called for requirements of the NOC, making it look like they have higher levels of education/literacy/numeracy/aptitudes than is really the case.

5. Many jobs in fact may be less or more demanding than suggested by the aptitude and other requirements in the NOC, which reflect “average” requirements for an occupation. For example, hotel clerks in big chains may require completion of university/college programs, while small family-owned hotels typically don’t, and a similar approach is true for chain grocery store cashiers versus family-owned variety store cashiers. Thus, in the case of a claimant who premorbidly was a cashier in a small family-owned grocery store, the TSA may enter education and aptitude levels for the big chains, making it look as though the individual’s pre-MVA skill/educational base was more substantial than in reality.

6. TSAs often use a wage database that is either U.S.-based, averaged across experience levels, or otherwise incompatible with the mandatory FSCO wage table.

The following case example demonstrates the importance and best practice of fully measuring claimant’s academic and aptitudinal data rather than relying upon a computer-generated report. A clinical thumbnail sketch of the case is presented, followed by a summary of the psychologically based occupational activity limitations, and the post-104 occupational analyses.

Case Example

- fifty-five-year-old, English as a second language speaking, foreign-born male
- two-year post secondary education
- pre-MVA press machine operator
- left hip fracture; chronic pain

- psychological diagnoses formally made only at two years’ post-accident during the post-104 week psychovocational assessment, as follows:
  - PTSD, with ongoing in-vehicular/pedestrian phobia
  - major depression, partially resolved with mild Adjustment Disorder with Anxious Mood, irritability

Occupational activity restrictions stemming from psychological diagnoses:

- For the foreseeable future, activities that should be avoided, at least initially:
  - frequent driving related activities
  - frequent multitasking activities
  - frequent work disruptions
  - frequent and substantial visual or auditory distractions, including working in close proximity to others
  - highly paced work environments/occupations (e.g., assembly-line/quotas, frequent short turn around deadline pressures)
  - high stress occupations
  - fast-paced/dangerous machinery
  - frequent high level, fast-paced conversations
  - frequent new learning demands

Disability Analysis of “Education, Training or Experience”

- Education:
  - Two years of college in fine arts abroad.
  - In all past work experience, education/academic abilities were non-essential.
  - Academic (English-based) testing: grade 5 level spelling and reading comprehension levels, and grade 5 arithmetic.
  - Functionally, academic achievement at pre-high school level, but credentials above that given two-year college program.
  - Practically, earned high school level education may be a market advantage over those without high school education, but claimant remains disadvantaged by poor
functional academic levels for occupations requiring high school level academic skills.

- Overall, claimant is assessed at partial high school completion (selected as a compromise between his stated level of attainment and current tested levels).
- Occupations based on education/cognitive profile aptitudes (adjusted for best representation in consideration of all administered cognitive measures):
  - Recreational Facility Attendant (semi/sedentary) (NOC 6670.5), Ticket Taker and Usher (NOC 6683.6), Food Service Counter Attendant and Food Preparer (NOC 6641), Parking Lot Attendant (semi/sedentary) (NOC 6683.5), Gas Station Attendant (NOC 6621).

- **Training:** No formal occupationally related training recognized
- **Experience/Career Path:**
  - 1997: two months in 1997/98 Assembly/Quality control for Lily Cup earning $9 per hour;
  - 1998-2000 Bender for a steel manufacturer earning $9 per hour;
  - 2000 until the accident Press Operator for Norris Packaging earning $12 per hour.

**Analysis:** In light of the generally speedy nature of these tasks, and his poor performance in areas of form perception, motor coordination, finger dexterity and manual dexterity (all in the below average range), the claimant is unable to perform at a competitive level in these occupations.

This example clearly drives home the point that a transferable skills analysis would have resulted in a gross overestimation of the individual’s actual aptitude levels and academic abilities, assuming that two years’ post high school had been entered (with the computer database treating this as synonymous with Canadian-based education in English/French, rather than in a foreign language).

Similarly, the TSA would likely have entered motor and psychomotor, and possibly several other aptitudes at a higher level than his tested level, on the basis of his semi-skilled past work history, *i.e.*, on the basis of the highest indications of NOC ratings of aptitudes generally characteristic of each past occupation. In reality, however, his MVA related physical and emotional impairments clearly resulted in lower post-morbid tested aptitude levels.

**Post-104 Week Case Law Criteria**

Similar to the pre-104 case law that serves to add an interpretative layer to disability determination, there are important legal principles which now inform state of the art methodology and form the principles of post-104 week disability determination. Those principles are as follows and will be detailed throughout the remainder of this section:

- suitability of post-morbid employment, maintaining reasonable remuneration and status
- submaximal effort does not necessarily invalidate testing
- occupations need not be exhaustive
- demonstrated competitive work quality
- self employment considerations
- work ready, without retraining
- work cannot promote condition aggravation/worsening.

**The Nature of Suitability**


> A reasonably suitable job is one which is comparable to the applicant’s pre-accident occupation in nature, status and remuneration. An applicant is not required to engage in trivial or inconsequential work, work for which he or she is overqualified, or work which he or she is completely unsuited for by background.

Given the case law mandate, this principle may be integrated clinically as demonstrated by the remuneration Table 1 below, which is extracted
from one of the author’s (JDS) psychovocational assessment reports. Each occupation under consideration on the left is contrasted by earnings relative to the base (pre-accident earnings) in the right-hand column. The table below demonstrates the substantive income loss relative to pre-MVA earnings.

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Less than 36 months</th>
<th>36 months but less than 120 months</th>
<th>120 months or greater</th>
<th>*Earnings retention vs. reported pre-MVA earnings ($42,000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recreational Facility Attendant</td>
<td>$22,045</td>
<td>$35,823</td>
<td>$44,780</td>
<td>52%</td>
</tr>
<tr>
<td>Ticket Taker and Usher</td>
<td>$19,978</td>
<td>$27,526</td>
<td>$39,269</td>
<td>48%</td>
</tr>
<tr>
<td>Food Service Counter Attendant and Food Preparer</td>
<td>$15,155</td>
<td>$21,491</td>
<td>$31,690</td>
<td>36%</td>
</tr>
<tr>
<td>Parking Lot Attendant (semi/sedentary)</td>
<td>$19,978</td>
<td>$27,526</td>
<td>$39,269</td>
<td>48%</td>
</tr>
<tr>
<td>Gas Station Attendant</td>
<td>$15,155</td>
<td>$20,708</td>
<td>$29,623</td>
<td>36%</td>
</tr>
</tbody>
</table>

*Calculation based upon “Less than 36 months” wage figure unless otherwise stated; wages from 2006 Financial Services Commission of Ontario Residual Earning Capacity tables.

Continuing with the example above, the related report then proceeded to derive an analysis on the basis of socio-economic status, and in regards to this aspect concludes:

**Socioeconomic Analysis:** The above occupations would appear to reasonably maintain his pre-accident socioeconomic status, given that the occupations reflect a level commensurate with the client’s pre-morbid Skill Level and Skill Type relative to the National Occupation Classification.

When the occupational earnings retention falls significantly below that of the pre-accident earnings, and/or if the socioeconomic status reflects a significant decline in the post-104 week occupations selected, then the evaluator would be obliged to recognize that the post-104 week disability test may in fact be met. However, in Ontario, there is no clearly established threshold with respect to either the benchmark earnings loss ratio or the socioeconomic decline for disability determination. Rather, this is discretionary in relation to the facts of the case. For instance, the Table 1 analysis above may suggest a significant remunerative incompatibility. However, if the individual had held the immediate pre-accident job with high earnings for a very short time, with income levels from other occupations being more synonymous with the post-accident occupations suggested, this may discourage the granting of post-104 IRBs. This differs from long-term disability policies which tend to have clearly defined earnings loss declines, depending upon the policy structure. At best then, the assessor is able to present data and arguably draw more substantive conclusions at the extremes, such as when there are sufficient occupations allowing for at least 80 per cent earnings retention, as well as where there is across the board under 50 per cent retention (particularly when higher pre-MVA earnings lasted over a considerable time period).

**Submaximal Effort Considerations**

In the case of *L.F. v. State Farm Mutual Automobile Insurance Co.*, [2002] O.F.S.C.I.D. No. 122 (FSCO A00B 000364, August 21, 2002 (upheld on appeal)), the multidisciplinary evaluators noted the presence of submaximal effort on the part of the claimant. The arbitrator clearly indicated that *unconscious* submaximal effort does not necessarily invalidate testing. The point being recognized here
is that if the submaximal effort is an inherent characteristic of the physical or psychological impairment, or an understandable behavioural related outcome, then such should not act against the claimant but should be considered part and parcel of their legitimate impairments. As such, client presentations characterized by significant chronic pain, depression and/or organically based apathy for instance, may be viewed as having inherent amotivation syndromes consistent with their presenting conditions and thereby accounting for their “submaximal effort”.

**Occupations Need Not Be Exhaustive**

This criterion relates to the principle that for practical purposes, the claimant need only be tested against a reasonable subset of occupations, such that he or she does not need to prove the inability to perform all conceivable occupations:

…the applicant is not required to prove the impossible; i.e. that the applicant is unable to perform every employment or occupation for which he/she is reasonably suited.


**Worker Productivity, Quality, Competitive and Readiness Factors**

In keeping with the competitive productivity requirements of the pre-104 week IRB test, there are parallel requirements in the context of the post-104 week IRB test. The following quotations clearly establish that the post-104 week test also demands that the claimant be considered on the basis of his or her ability to perform at least one of the identified occupations on a competitive basis:


- “If the applicant’s performance on … testing fails to result in competitive levels of speed, accuracy, consistently, longevity and productivity sufficient to be employable in one of the identified suitable occupations, the applicant satisfies the ‘Complete Inability’ test”. *(Terry v. Wawanesa Mutual Insurance Co.,* [2001] O.F.S.C.I.D. No. 102 (FSCO A00-000017, July 12, 2001); *L.F. v. State Farm Mutual Automobile Insurance Co.,* [2002] O.F.S.C.I.D. No. 122 (FSCO A00B 000364, August 21, 2002 (upheld on appeal))

- “There is no better evidence of incapacity to perform a task than the failure of an honest and sustained attempt to do it”. *(Foden v. Co-

• “It might at first glance seem anomalous to hold that a person who has returned full-time to work and who is receiving full pay is at the same time “totally disabled”. The anomaly is more apparent than real. First, on the facts, the plaintiff’s employer did not keep her on because he was satisfied with her work. He was not satisfied. He kept her because he hoped she would improve, notwithstanding that she was not capable of doing what was expected of her and that the quality of her work had deteriorated. It is open to an employer to keep on an employee whose work is not satisfactory just as it is open to him to terminate the employment. As I have observed, those facts standing by themselves may mean little. To be terminated does not prove that an employee does not have the capacity to perform a task nor does to be kept on the payroll prove that he has”. (Foden v. Co-Operators Insurance Assn., [1978] O.J. No. 3487 (H.C.J.), at paras. 55-56 (underscore added).

• If the applicant requires more than minimal retraining to do the job, the job is not suitable and the claimant meets the test. (Horne and CIBC, [2001] O.F.S.C.I.D. No. 193 (FSCO A00 B 000291, December 20, 2001)

Rejection of Self-Employment

A not uncommon set of recommendations emerging from vocational and psychovocational recommendations over the years was that the claimant would be capable of self-employment and as such, not eligible for post-104 week income benefits. However, in Lee and Certas, [2006] O.F.S.C.D. No. 98 (FSCO A03-000041, June 15, 2006) this issue was eloquently and thoughtfully addressed. While these authors were unable to identify similar references, it serves as a very pragmatic reality check on such recommendations:

[115] [The vocational evaluator] recommended that she consider self-employment involving answering telephones in a home office. This would allow [her] to change positions at will. [The evaluator] noted that [her] success will depend on her ability to market her services and obtain clients, and that until she became established, she might have difficulty obtaining a wage comparable to what she earned pre-accident. I find no evidence that [she] has any of the requisite skills for marketing, obtaining clients, billing, collecting accounts and running a business. I find that in most cases, self-employment would be such a different enterprise from regular employment, that the two cannot be equated.

Final Considerations and De-emphasized Factors

An obvious consideration in the case law is the question of whether or not the individual must be prevented from working on a continuous basis in order to be in receipt of post 104 week IRBs. While other disability systems such as Canada Pension Disability explicitly require continuous inability, in Lee and Certas, [2006] O.F.S.C.D.No. 98 (FSCO A03-000041, June 15, 2006), the following opinion was given:

[85] In this regard, I also note that the test for post 104-week benefits does not contain any requirement or refers to any definition that requires Ms. Lee to be ‘continuously’ prevented from working. I agree with the arbitrator in the Lombardi case, that the drafters did not intend periodic work to necessarily bar benefits in relation to the overall analysis of a work disability.

The last criterion which we shall consider is one which is also an important factor in combination with the competitive work concept, and that is the notion of the degree to which one’s underlying condition reacts in the context of work demands and stress:

If the jobs identified by the assessors as suitable are discordant with the applicant’s ambitions or would promote depression or deterioration in the applicant’s conditions, it is unreasonable for the jobs to be considered suitable (Atavar v.

While all of the above case law criteria clearly put flesh on the meat of the ‘any occupation’ test, it is also important to note that there appears to be a de-emphasis on considerations of job availability/existence and of one’s capacity to travel to work (assuming that travel is not an essential job task). There have been limited exceptions with respect to the capacity to travel to work, such as the presence of claustrophobia impairing the individual’s ability to travel. By contrast, however, these factors are typically well considered in tort loss of earning capacity and competitive employability analyses.

Summary of Post-104 Week Case Law Influenced Criteria

To ensure that the evaluator has given sufficient consideration to the above referenced case law, the following questions should be asked in the final analysis towards addressing the post-104 week disability test:

1. Are the selected occupations commensurate in nature, status and remuneration to the claimant’s pre-accident training, education and experience profile?

2. Can the claimant perform the essential job tasks of each occupation at a sustained and competitive level, with minimal further (re)training/rehabilitation?

3. Would the identified occupations avoid aggravating the individual’s condition and avoid fostering a worsening of MVA-related impairments?

With respect questions number 2 and 3 above, an evidence-based response cannot be obtained in most circumstances on the basis of a psychovocational evaluation alone, and/or in concert with a few hours’ functional ability evaluation. Nevertheless, many IME/insurer examiners and even plaintiff-oriented evaluators do not go beyond the provision of these sole evaluations.

While this combination is very appropriate for the identification of the target occupations considered to be potentially “suited by education, training or experience”, in isolation they are unable to consider the competitive employability and related criteria discussed in the case law cited above. The depictions below, however, differentiate the two models, the first of which is a traditional one-stage model, while the second one reflects a state of the art, case law compliant, two-stage model. While the first stage is shared between the models, the key aspect of the second stage is that of the inclusion of a multi-day situational work assessment. The situational work assessment involves simulated work tasks corresponding to each of the target occupations under consideration, typically including some standardized work sample technology in conjunction with non-standardized activities. While the length of these assessments may vary up to an ideal of five consecutive days, we minimally recommend two days for non-brain injured and three days for brain injured clientele. Of course, with respect to question 3 above, even a five-day situational assessment is unlikely to ascertain whether a given occupation may foster condition worsening over the medium to longer term. An acknowledged criticism of multi-day situational assessments is that pain for instance may be aggravated over a period of a few days before the individual acclimatizes to an increase in daily activity level relative to his or her prior non-work status. However, this criticism is not one of situational assessment methodology, but rather of its length. The latter is typically more of a funding consideration, or rather, one of cost limitations by funding parties.
Figure 4. Stage 1, “Any Occupation” Disability Determination

Stage I: “Any Occupation” Disability Determination

1. Illness/Injury
   - Physical Impairments
   - Emotional Impairments
   - Cognitive Impairments

2. Physical Abilities/Limitations
   - General F.A.
   - Significant Cognitive Impairment
   - Neurovocational Assessment

3. Personal & Vocational Characteristics
   - Minimal Cognitive Impairment
   - Psychovocational Assessment

4. Potential Job Alternatives

Many insurers/IEs/s. 24 inappropriately stop at this stage.

Figure 5. Stage 2, “Any Occupation” Disability Determination

Stage II: Competitive Employability & “Any Occupation” Disability Determination

1. Illness/Injury
   - Physical Impairments
   - Emotional Impairments
   - Cognitive Impairments

2. Physical Abilities/Limitations
   - General F.A.
   - Significant Cognitive Impairment
   - Neurovocational Assessment

3. Personal & Vocational Characteristics
   - Minimal Cognitive Impairment
   - Psychovocational Assessment

4. Competitively Employable?
   - Productivity
   - Sustained concentration & work pace
   - Work-like demeanor
   - Stamina over full work day/week

5. Work Trial

6. Situational Work Assessment

Dr. J. Douglas Salmon, Jr. © 2001, 2006
Best Practices Summary for Post-104 Week Disability Analysis

The following principles reflect our recommendations for best practices in accordance with the evolving case law, as reviewed above, with respect to post-104 week disability evaluation:

- For brain injury cases, a neuro-psychovocational assessment should be performed ideally by a qualified neuropsychologist within one report, or alternatively in combination by a neuropsychologist and vocational psychologists in a single or two well-coordinated reports.
- A psycho/neurovocational post-104 week focused disability assessment should never present a general “laundry list” of occupations, but should be more focused on identifying a few “testable occupations”.
- A psycho/neurovocational post-104 week focused disability assessment should include earnings retention and socio-economic status analysis.
- Computer-based transferable skills analyses should not be utilized in the process.
- Physical/functional capacity assessments should not be restricted to traditional functional ability evaluations.
- Utilize multi-day situational work assessments and/or work trials to determine “competitive employability” and functional status relative to the selected target occupations.
- Utilize the questions above as a quality assurance checklist to assure that key case law criteria have been appropriately considered.

Conclusion of Part II

It was the intention of this paper to educate readers about pertinent case law and related evolving judicial/arbitral interpretations surrounding the post-104 income replacement entitlements within the Ontario MVA insurance system. By presenting the case law, best practices in disability assessment methodological and analysis were substantiated and elucidated in the context of holistic occupational disability assessment models. Comparative analysis was also utilized to inform readers of commonalities in case law evolution, such as the emphasis upon the quality of activity engagement across pre- and post-104 week spheres.

One area that the authors have highlighted is that the assessment of pain is more complex than is generally acknowledged in many disability assessments. Research on the impact of pain on individuals with disabilities and impairments arising from injuries sustained, clearly demonstrates that traditional pain measurements are inadequate to fully determine the disability arising from pain. Also, in establishing recommendations to returning disabled individuals to work, the principle of competitive employability is often not utilized as it should be in accordance with existing case law.

In the final segment of this trilogy, the best practice methodologies for use in Situational Assessment and Simulated work trials, shall be explored with final considerations in relation to post-104 week oriented neuro/psychovocational assessments.

[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 is also involved in providing neuropsychological FASD assessments in the context of Gladue pre-sentencing considerations for convicted Indigenous persons and is actively developing FASD-related intervention/rehabilitation services for Indigenous inmates. Dr. Salmon’s multi-disciplinary clinics provide comprehensive rehabilitation services (<www.rtwintegratedhealth.com>) and multidisciplinary assessments (<www.synergyintegratedassessments.com>). 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.]
**Trillium Gift of Life Act and Why the Struggle with Organ Donation Persists in Ontario**

Hillary Chan

**Abstract**

Despite the creation of Ontario’s *Trillium Gift of Life Network Act* in 1990, Ontario’s prospect in organ supply remains low. Since 1990, medical findings have informed and changed approaches to organ donation; however, these approaches have not been implemented consistently across hospitals nor have they been integrated firmly into the law. This lack of consistency and integration, as research suggests, prevents organ donation rates from fulfilling their potential. In response to such downfalls, this article suggests areas in the *Trillium Gift of Life Network Act* that should be updated as a first step to improving organ donation rates.

Despite the Trillium Gift of Life Network (TGLN) increasing the number of organ donors by around 100 donors over the 2013 to 2015 period, Canadians remain “five to six times more likely to need an organ transplant than to become a deceased organ donor”. The deficit in organ supply grows more concerning as Canadian demographics begin to change. Although raising organ donation rates is a national concern, each province has its own organ transplantation laws. Accordingly, organ donation should be investigated at the level of provincial legislation. In Ontario, the *Trillium Gift of Life Network Act* (TGLNA) sets out organ donation laws along with the rights and obligations of the Trillium Gift of Life Network (TGLN), the government organization overseeing organ donations in Ontario. The mandates of TGLNA, which declares TGLN supports organ donation activities and educates the

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**References**

- Horne and CIBC, FSCO A00 B 000291, December 20, 2001

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public about organ donation, lack proper execution, which prevents significant improvement of Ontario’s organ donation rates.

The current reimbursement strategy created to meet the objective of supporting organ donations opposes the goal of s. 10 of TGLNA without effectively increasing organ donation rates, and negatively changes the appeal of organ donation. Section 10 of the TGLNA prohibits direct or indirect selling of organs of “valuable consideration”. The United States, which has contemplated reimbursements and tax exclusions for organ donors before, still interdicts such financial incentives due to their National Organ Transplant Act, which delineates the same rule as s. 10 of the TGLNA. Conversely, because s. 8.12 states that the TGLN must comply with the Health Minister’s instructions, the TGLN, in 2008, followed the government’s decision to reimburse living donors.

According to the Ontario government, reimbursements are necessary because donors “should not suffer financial loss” for delivering “one of the most generous acts anyone can perform”. Particularly, the reimbursements were designed to overcome disincentives regarding organ donations. Current reimbursements cover a donor’s ancillary expenses during the organ donation up to $5,500, but do not cover other costs. This amount does not compensate for the financial loss from not working while recovering from an organ donation. So it is not surprising that these reimbursements have not significantly helped with increasing organ donation.

The specific conflict in the contradicting values conveyed between government orders and the TGLNA also alters the appeal of organ donation procedures. On an ethical basis, organ donation, as the name suggests, should be for beneficence, “emotional benefit from lifesaving” — arguably an indirect payment. The public already views the paperwork attached to organ donations as a trade-off that could enter a slippery slope to the brokering of organs. Financial reimbursements could worsen the ethical appeal of TGLN.

As the U.S. Department of Health & Human Services explains, having financial reimbursements turns organ donation into the oxymoron “rewarded gifting”. Such change revolutionizes the framing of organ donation; donors become vendors, thereby framing the body as a commodity, “sold and bartered…similar to any other good or service”. Even though Ontario’s reimbursements are not yet financially lucrative enough to influence donation rates, a potential implication would be the development of the public fear of “organ vendors” demanding higher prices (or better reimbursements in this case), for their “donations”. As well, the financial burden for Ontario will increase due to the TGLNA’s allowance for government powers to use financial incentives in order to arguably increase healthcare efficiency. The split message that reimbursements make with s. 10 shows that the TGLNA requires amendment in order to frame policies that publicly display unified aims and, therefore, strategy to support organ donation.

Aside from meeting an objective by opposing a section within the same Act, the TGLNA also lists public education about organ donation as a key responsibility of TGLN; however, this mandate remains minimally fulfilled since the TGLNA has limited ability to ensure the method of education or the content of the information is effective or precise. The TGLNA has no power over how objectives are achieved, so the delivery of its educational materials lack improvement, which leaves organ donation rates from certain populations constantly low. According to Li, et al. (2015), the two largest visible minorities in Canada, Chinese and South Asian, are much less likely to register or to consent for organ donations due to misconceptions about donations.
These ethnicities convey fear of disfigurement from organ procurement and distrust medical systems due to black organ markets in their home countries. So it is not surprising that 90 per cent of organ donors in Ontario are Caucasian. Despite TGLN’s purported efforts to better communicate to a diverse population, TGLN’s educational strategies have not made significant improvements on donation rates from minorities since Asian immigrants continue to exemplify low donation rates.

Currently, TGLN’s endeavors to educate the public consists of online postings about the need for organ donations and how to consent to donation. Additionally, the website and information distributed by TGLN is only in French and English. Of course, there may be pamphlets distributed in different languages, but the inconsistency with other forms of media hampers the implementation of promotional activities regarding organ donation in a multicultural setting.

In the early 2000s, educational campaigns were planned, but such campaigns have not been executed since that time. By solely relying on online material and pamphlets for public education without campaigning, TGLN arguably satisfies the TGLNA’s mandate to educate the public about organ donation. Contrarily, the language barrier and the lack of content that addresses misconceptions conveyed by visible minorities would only reach those who are fluent in Canada’s official languages, who understand how to navigate the website, and who have the curiosity to seek this information. The information will not extend to members of the public who already carry misconceptions, reject the idea of organ donation, and as a result, refuse to seek more information about the matter. Evidently, under the TGLNA, TGLN only acknowledges its mandated objectives. The TGLNA has no power to warrant an effective pursuit of these objectives, which generally hinders efficient raising of organ donation rates.

In addition to the ineffective delivery of education about organ donation, the TGLNA’s unclear definitions of deaths that are admissible for organ procurement contributes to confounded educational content about deceased organ donation. Section 7 of the TGLNA loosely states that a minimum of two doctors must determine the death of the donor according “to accepted medical practice.” Such a statement would suffice if the types of deaths accepted for donation had not recently expanded. In the past, organ donations in Ontario had always relied on brain-dead donors (DBD). In response to the low supply of organs, the government opened their deceased donor criteria to cardiac-death donors (DCD).

While expanding the deceased donor criteria and the few restrictions that the TGLNA’s s. 7 imposes on such criteria should help increase organ donations overtime, the insignificant enforcement of provincial standards in identifying and managing DCDs actually reduce future donations. Unlike DBD, there are two types of DCDs: controlled and uncontrolled. Controlled DCD occurs with pre-planned cardiac death whereas uncontrolled DCD, the most common and varied in its identification, occurs with unexpected cardiac arrest. While Europe has established more standardized protocols for the different types of DCDs, determining a deceased patient as DCD in Canada varies by hospital, which jeopardizes the ethical and legal justification of DCD.

In fact, the lack of a provincially standardized framework for determining or managing DCD hinders the increase in organ supply by 20-50 per cent. Without standardized DCD protocols, TGLN cannot fully educate the public on how potential donors are identified since TGLN itself does not have precise criteria on how and when different types of deceased donors are ready for donation.
At times, a number of mandates in the TGLNA act more as policies and guidelines than firm laws. The TGLNA certainly ensures that TGLN’s operations meet legislated obligations to some degree. Sadly, the TGLNA has no measure to guarantee that TGLN meets its objectives more effectively. At the same time, the TGLNA cannot protect its legal power when the provincial government decides to make a change against what is stated within the Act. Last, limits of the TGLNA to amend its sections according to the speed and change in demographics or medical considerations like DCD may endanger the way present and future decisions for organ donations are made. Without the political power, the facility to ensure full accountability from TGLN, or the adjustability to a constantly changing society, the TGLNA mainly prevents organ donation rates from accelerating to its full potential in Ontario.

[Editor’s note: Hillary Chan, MHSc candidate, HBSc, is a research analyst at the Toronto General Hospital and a graduate student of the Translational Research Program under the University of Toronto’s School of Medicine. Previously, Hillary had worked in research at St. Michael’s Hospital, Sunnybrook Hospital, and Shandong University School of Medicine. If you wish to contact the author, please send an e-mail message to <info@hlcj.ca>.]  

1 Trillium Gift of Life Network 2015.  
2 Sonya Norris, Organ Donation and Transplantation in Canada (Ottawa: Library of Parliament, 2011) [Norris].  
4 Trillium Gift of Life Network Act, R.S.O. 1990, c. H.20 [Trillium Gift of Life Network Act].  
5 Ibid.  
6 Ibid.  
8 Trillium Gift of Life Network Act, supra, note 4.  
10 Ibid.  
14 Norris, supra, note 2.  
16 Ibid.  
18 Trillium Gift of Life Network Act, supra, note 4.  
21 Canadian Institute for Health Information, Deceased Organ Donor Potential in Canada (2014) [Canadian Institute for Health Information].  
22 Ibid.  
23 Norris, supra, note 2.  
24 Trillium Gift of Life Network Act, supra, note 4.  
25 Canadian Institute for Health Information, supra, note 21.  
26 Shemie, supra, note 3.  
28 Ibid.  
29 Canadian Institute for Health Information, supra, note 21.  
31 Chapman, supra, note 27.
Current Events

Anna Okorokov

Events

July 14, 2016–August 4, 2016
Health Informatics Bootcamp 2: The 12 Challenges in Advancing eHealth
Toronto, ON

September 14, 2016
Health Law in Canada in partnership with the Institute for Health, Policy, Management and Evaluation, University of Toronto
A Roundtable on the Canada Health Act: Version 2.0
Hart House, University of Toronto

September 16, 2016
Enterprise Risk Management in Health Care Settings
Courtyard Toronto Downtown
Toronto, ON

September 26–27, 2016
International Conference on Men’s Health
Toronto, ON

October 3–5, 2016
Canadian Health Workforce Conference 2016
Ottawa ON

October 16–17, 2016
The 6th Global Forum on Health Promotion
Charlottetown, Prince Edward Island

November 17–18, 2016
Advancing Food Insecurity Research in Canada
Toronto ON

November 19–21, 2015
University of Ottawa
Ottawa, ON

Movers & Shakers

Dr. Siddika Mithani became President of the Canada Public Health Agency on April 11, 2016.

Dr. Verna Yiu has been named Alberta Health Services President and CEO.

Michael Mayne has been hired as the new chief executive officer of Health PEI. Former CEO Dr. Richard Wedge retired in May.

Ron Van Denakker has been named as the Interlake-Eastern RHA’s new chief executive officer (CEO) following the departure of John Stinson.

Mike Parker will take over as president of the Health Sciences Association of Alberta following the resignation of Elisabeth Ballermann, who served as president from since 1995.

Professor Paul W. McDonald has been appointed as Dean for a five-year term at York University’s Faculty of Health.

Dr. Karen Grimsrud has been appointed as Alberta’s new Chief Medical Officer of Health.

[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> .]

[Correction: We regret that Dr. Helen Sendro-vich’s name was spelled incorrectly in the May edition of Health Law in Canada and apologize for the error.]
SAVE THE DATE

A ROUNDTABLE ON THE CANADA HEALTH ACT: VERSION 2.0
Annual HLCJ-IHPME Conference

Wednesday, September 14, 2016
8:30 a.m. – 5:30 p.m.
Hart House, University of Toronto
Details to follow