

Chapter 5

MEDICAL EVIDENCE

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MEDICAL EVIDENCE

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1. INTRODUCTION

In many workers' compensation cases, the central issue in dispute is a medical one. For example, the issues of work-relatedness and level of disability or impairment are often central to an appeal. Good representation requires thorough research of the medical issues, the development of a sound medico-legal theory of your case, and careful assembly of supportive medical reports and literature. This chapter:

- considers the initial concerns of the costs of medical care and obtaining medical reports, as well as the issues of choosing and changing health care professionals;
- covers some of the factors that typically affect the weight of medical opinions; these include the qualifications of doctors and other health care professionals, the assessment of Board medical opinions, the uses of new evidence, and the types of diagnostic tests and procedures used by the doctors involved;
- addresses the role of advocacy in the collection of supportive evidence, including a review of the protocol regarding doctors' reports and factors that must often be considered when writing to a doctor to request a report;
- refers to the law, policy, and practice regarding the use of doctors as witnesses at hearings, as well as relevant advocacy issues; and
- discusses where to get further medical opinion or to research particular points.

2. THE COST OF MEDICAL CARE AND EVIDENCE

2.1 Examinations and Treatments

The Board is responsible for the cost of health care, including the examination and treatment of injured workers, pursuant to s.33 of the Act. For examination and treatment, physicians submit all accounts to OHIP. The Ministry of Health and Long-Term Care tracks the cost of work-related injuries and diseases and bills the Board later. For health services not covered by OHIP, such as homeopathic treatment or preparation of a report, health care practitioners must bill the Board directly. However, these bills will be paid only if the Board approves the service. The Board is notoriously slow in making payment and its fee schedules are often at levels below the rates charged to patients.

2.2 Reports Requested by the Board

Under s.37, all health care practitioners and institutions are required to provide reports requested by the Board. The Board has a series of standard medical report forms for different issues. It is the Board's practice, when requesting reports on a worker's state of health, to have the worker sign a "waiver" or consent to release of information form. This form is sent to the doctor along with the Board's request. The Board pays for the various reports it requests according to a fee schedule which is posted on its website at:

www.wsib.on.ca/wsib/wsibsite.nsf/public/HealthProfessionalFees.

In cases where an adjudicator asks the injured worker to obtain medical confirmation of some routine or straightforward fact, it is reasonable to tell the Board to request this information directly from the doctor pursuant to s.37. If requested by the injured worker or their representative, the doctor may charge a fee on the basis that it is a "third party medical" as mentioned in Section 2.3 below. The Board can also request an injured worker to co-operate in health care measures and go for a medical examination by a health care professional of its own choosing pursuant to ss.34 and 35 of the Act. If the injured worker does not co-operate, the Board can reduce or suspend benefits. (See Chapter 19: Medical Rehabilitation, Section 3 on the failure to co-operate and absenteeism, and Chapter 26: Loss of Earnings, Section 3.5 on suspension or reduction of LOE.)

When time is of the essence for the injured worker, such as in initial entitlement issues, it may be advisable for the injured worker to personally pick up the correct Board medical form (if the doctor does not have it), take it to the doctor for completion, and then hand deliver it to the adjudicator. You should advise the injured worker to retain a copy with a note of the date and time of delivery to the Board. If the adjudicator is not available to take delivery of the report, the injured worker should write the adjudicator's name on the envelope and mark it "Personal and Confidential". In Toronto, this should ensure direct delivery through the internal mail system at the head office.

2.3 Reports Requested by Representatives

Medico-legal reports requested by representatives are considered "third party medicals" and are not paid for by OHIP. Many family doctors and most specialists charge a fee for these reports. These fees are not standardized and usually range from \$100 to \$1,000, but can be much more. However, keep in mind that there are a number of occupational health clinics around the province that will assess workers and provide a report at no charge (see Appendix 5-B).

Some doctors are willing to reduce or waive their fees for reports if they are aware that the request comes from a non-profit community organization, such as a legal clinic, that is assisting their patient without charge. However, some clinics have found that requesting reduced fees has resulted in lower quality medical reports. In community legal clinics, these expenses can be covered initially by the legal disbursements budget, but they can often be recovered from the Board or the WSIAT as described below.

If paying for a report is a problem, representatives should let the doctor know this when the report is requested. Options include:

- advising the doctor of the nature of your organization;

- requesting the doctor to waive or reduce the usual fee;
- offering a set fee;
- telling the doctor that the worker will be responsible for the cost of the report; or
- asking the doctor to call before writing the report to advise you of the potential cost. This may avoid a later disagreement over the bill which could interfere with the injured worker's relationship with the doctor.

The Board will reimburse you for all or part of the cost of a medical report paid for by, or on behalf of, an injured worker if the report was relevant to the adjudication of a claim. The Board's OPM, Document 17-02-03 refers to the report being useful and/or necessary to the adjudicative process. Write to the claims adjudicator or to the health care benefits adjudicator and request reimbursement pursuant to the above-noted policy and s.37 of the Act. As discussed above in Section 2.2, the Board will often pay only up to the amount on the Board's fee schedule for reports it requests.

You can also make a request for reimbursement at a Board hearing. It does not matter whether or not the appeal is successful because the worker has the right to appeal, and the Board requires new medical evidence to overturn a decision based on the medical evidence already on file.

Under s.133 of the WSIA, the Tribunal can also refund certain medical expenses related to an appeal. A "Hearing Expense Claim" is available at the reception desk in the Tribunal's Toronto office, or from the vice-chair or panel at a regional hearing. According to the Tribunal's Practice Direction on Fees and Expenses, fees for evidence obtained by the parties from professional witnesses are paid only if approved by the vice-chair or panel. It says that a panel may approve payment if a professional report is found to be significant in the decision-making process or if oral evidence given by a professional witness has proved to be of exceptional importance to the decision-making process. When payment for a party's medical witness fees is ordered, the Practice Direction says that payment is based on the Tribunal's approved schedule of rates rather than actual costs. For example, at the time of writing, witness fees on their website are \$300.00 for attending a half day hearing and up to \$600.00 for a full day's hearing. Their fee schedule for medical assessments and reports is not on their website and must be obtained through the Tribunal's Medical Liaison Office.

In Decision 522/01AD (13 June 2003) the panel stated:

In our view, a request for the reimbursement of a medical report obtained in preparation for a Tribunal hearing should generally be made at the hearing before the vice-chair or panel deciding the appeal. Failure to do so may result in an increased risk that the request will be denied.

In that case, the worker requested reimbursement of \$3,500 for a medical report from an orthopedic surgeon for use in his appeal. The Medical Liaison Office advised that its schedule provided a rate of \$224.20 per hour for a maximum of five hours for preparation of a report by a doctor, and an additional payment of \$112.10 when substantial review of records was required. The panel was satisfied that the report was significant in the decision-making process but decided there was no reason to deviate from the Practice Direction. They approved the

maximum payment according to the schedule for five hours of preparation and the additional amount for review of records, for a total of \$1,233.10.

In Decision 2429/01 (28 May 2002), the injured worker appealed the Board's refusal to reimburse the worker for \$4,000 for a report she obtained from a clinical psychologist after the Board wrote and invited her to submit additional medical information. The vice-chair concluded that the Board should reimburse the worker for the cost of the report, but only to the extent of the usual fee schedule used by the Board.

While requests for reimbursement of the cost of medical reports have become routine, care should still be taken to address the relevant Board policy or WSIAT Practice Direction in making the request. The Tribunal approaches these requests cautiously and often refuses payment. For example, in Decision 1103/00 (27 June 2000), the vice-chair denied reimbursement to the injured worker for the cost of the medical report since it was essentially the same as a prior report and, therefore, not significant in the decision-making process. In Decision 829/01 (29 March 2001), the injured worker appealed the refusal by the Board to reimburse him for \$10 spent on a medical certificate from his family doctor. The vice-chair ruled that Board policy provides for payment for requested medical reports or reports used solely to adjudicate claims. There was no evidence that the certificate in this case was requested by the Board or used solely to adjudicate claims. The worker was not entitled to payment for the medical certificate.

2.4 Reports Requested by the Employer

Section 36 of the Act creates the right of an employer to request an injured worker to submit to a medical examination by a health care professional chosen and paid for by the employer. For a detailed discussion of s.36 requests, see Chapter 6: Employer Issues, Section 4.

Section 37 of the Act creates the right of an employer to request medical information directly from an injured worker's treating health professional. Under s.37(3), the health professional is required to provide certain information concerning the worker's functional abilities when requested. The injured worker is required by s.22(5) to consent to this in advance, at the time of initiating the claim. The Board is required to pay for the reports pursuant to s.37(5). The contents of the Functional Abilities Form (FAF) are prescribed by O.Reg. 456/97.

3. CHANGING DOCTORS

3.1 Choice of Doctors

The right to choose one's doctor or seek a second opinion is basic to our health care system. However, injured workers whose health problems are the subject of a Board claim often find themselves viewed in a different light. Frequently, they are treated with the suspicion that the worker is shopping for a doctor who will say what is needed to obtain workers' compensation benefits, regardless of the truth.

Even if a worker changes doctors because the treating doctor does not believe the disability exists or is work-related, it does not necessarily reflect on the validity of the claim. In the Tribunal's leading case on pension assessment, the medical experts testified that, in cases of chronic disabling pain without apparent physical cause, "a significant proportion of such cases

will in fact involve pain that is being generated by organic processes which have been missed in the medical diagnosis or which are beyond the reach of current diagnostic techniques”.¹

3.2 Board Policy

Subsection 33(1) of the Act states that the injured worker has the right to make the initial choice of doctor or other health professional. This choice is not made when the injured worker initially seeks treatment on an emergency basis. Often the injured worker will seek first aid from the company doctor or a nearby hospital or doctor. The choice of doctor is made when the injured worker accepts treatment after the initial or emergency treatment.²

OPM, Document 17-01-03 provides that once the injured worker has made this choice, it is necessary to request, in advance, the permission of the Board to change doctors. This policy lists several acceptable reasons for making such a change and these reasons are sufficiently broad that they can be adapted to cover almost anything. A worker may choose to change doctors for reasons such as communication difficulties due to language problems, travel distance, concern about the treatment choice because there is no improvement in his or her condition, or a personality conflict. Board policy also notes that if an injured worker changes health care professionals without permission, the Board may not pay for the treatment and may reduce or suspend benefits under OPM, Document 22-01-03 for breach of the worker’s obligation to cooperate with the Board.

3.3 The Alternatives

If an injured worker chooses not to request Board approval in advance of a change of doctors, or has already made a change, it should suffice to send a letter to the Board confirming the change and the new doctor’s name, address, and telephone number. If a short explanation of the reason is given, this may pre-empt any negative inferences that might otherwise be drawn.

If the Board refuses to permit a change of doctors, there are potential remedies under the *Regulated Health Professions Act, 1991*³ (RHPA) (described in Section 12 below) and the *Ontario Human Rights Code*.⁴ The Canadian Medical Association Code of Ethics⁵ provides that an ethical physician will recognize that the patient has the right to accept or reject any physician and any medical care. Board policy clearly contradicts this code. However, a complaint to the College of Physicians and Surgeons of Ontario regarding this policy and its use by Board doctors was not accepted as professional misconduct by the Health Disciplines Board.⁶

Under s.1 of the *Ontario Human Rights Code*, people in Ontario are guaranteed access to services without discrimination on the basis of disability. Disability is defined in s.10(1)(e) to include a compensable injury. Since people in Ontario have the right to choose their own doctor, and since the WSIA, or at least the policy, limits this right for people with compensable injuries, the Act and policy appear to contradict the *Code*. A Board decision refusing to allow an injured worker to change doctors could be the subject of a complaint to the Ontario Human Rights Commission. However, if you and the worker are considering this course of action, be advised that delays at the Commission are extremely long.

A decision to deny permission to change treating doctors should be appealed to an appeals resolution officer (ARO) and the WSIAT if necessary. It is likely that the WSIAT would accept the validity of the arguments noted above. In order to avoid delaying consideration of more substantive issues in a file, such appeals should be combined with one or more other appealable

issues. Since doctors now bill OHIP and not the Board, appealing on this point should not interfere with the injured worker's treatment.

4. QUALIFICATIONS OF DOCTORS

Representatives need to know the qualifications of doctors in order to be able to make arguments about the weight that should be attached to the medical reports they provide. Basic information such as medical school and date of graduation, professional and hospital affiliations, specialty or other post-graduate qualifications, is available in the *Canadian Medical Directory* (see Appendix 5-A). The Tribunal requires the *curricula vitae* of doctors who have prepared reports for a Tribunal appeal.

4.1 Basic Training

A worker's family doctor or general practitioner must be licensed by the Ontario College of Physicians and Surgeons. The College serves a self-regulating function for physicians pursuant to the RHPA.

Some general practitioners may have additional training or education in relevant fields which would give their opinion more weight, for example, an MOH (Master, Occupational Health), a DOH&S (Diploma, Occupational Health and Safety), CCBOM (Certificate, Canadian Board of Occupational Medicine), or a DIMOH (Diploma, Industrial Medicine and Occupational Health).

Doctors may also be certified by the Canadian College of Family Physicians (CCFP). This is a national voluntary association directed towards continuing education. The designation of CCFP indicates that a doctor has completed a study or residency program, has passed the exam, and is certified by the College.

4.2 Specialists

Specialists are doctors who are licensed to practice by a provincial college and certified as specialists by the Royal College of Physicians and Surgeons of Canada (RCPSC), a national self-governing medical organization located in Ottawa (1-800-668-3740). All specialists are "certificants" of the RCPSC. Over 40 specific types of specialties are certified by the RCPSC in the Division of Medicine and the Division of Surgery. The complete list can be found in the *Canadian Medical Directory* (see Appendix 5-A). No other specialties are recognized as such in Canada. Watch out for Board doctors whose title suggests a specialty, one such as "industrial disease consultant" or "surgical consultant" which does not appear in this list of specialties.

An "F" designation refers to a fellowship, which requires a commitment to support the Royal College and to abide by its code of ethics and by-laws. For example, a "Fellow" of the Royal College of Physicians of Canada (FRCPC) is a physician who is certified in one of the specialties in the Division of Medicine and has been accepted as a fellow of the Royal College. The Royal College has continuing education programs for the maintenance of certification of its fellows.

5. OTHER HEALTH CARE PROFESSIONALS

5.1 Types of Care

Other than physicians, only chiropractors, optometrists, psychologists, and dentists may use the title “doctor” in providing health care. Many health care professionals involved with injured workers are not physicians. The amount of training or experience required to practice in these quasi-medical areas varies greatly. The governing legislation has been revised and consolidated by the RHPA which was proclaimed on January 1, 1994. It establishes certain health care professions as self-governing with a regulatory structure similar to that of physicians under the former *Health Disciplines Act*.⁷ Each is governed by its own College which is responsible for setting standards, licensing, and regulating the conduct of its members.

5.2 Treatment Fees

The cost of treatment by any health care professional may be covered by the Board. However, specific policies limit payment for most of them (for more detail see Chapter 21: Health Care Benefits).

6. EVALUATION OF MEDICAL EVIDENCE

6.1 Medical Lingo

A number of common medical expressions are used in Board medical reports. The following are explanations of some of the main ones:

“Organic” is used to refer to conditions which have a concrete, physical basis (a “pathology”) that may or may not have been identified.

“Inorganic” or “non-organic” is used to refer to psychological conditions and also to conditions which the Board believes to be wholly or partially psychological.

“Functional” and “functional overlay” have no real medical meaning. The terms are generally used by sloppy doctors who are unable to find an organic basis for the disability and think the disability might be psychological. These terms refer to a vague psychological process in which a disability is developed that serves (“functions”) to the benefit of the injured worker in some way. They are often used in a pejorative sense. An injured worker’s unexpectedly severe disability, or deterioration, or failure to improve as expected might be labelled “functional” by a doctor. Identifying a disability as functional is not necessarily the same as saying the patient is consciously exaggerating their disability; however, some doctors and Board staff do equate the two. If the terms “functional” or “functional overlay” appear in a report, it may be necessary to argue that this diagnosis should be understood in the medical sense of the word and does not reflect on the injured worker’s credibility or the compensability of the worker’s condition.

“Secondary gain” is an accepted psychiatric term that refers to an inorganic disability which has developed after a compensable physical injury through an unconscious mental process that serves to accomplish something (a “secondary gain”) that is of benefit to the injured worker. For example, it may be used to explain a possible reason for chronic pain. Severe or extreme

disability may more clearly establish the injured worker's inability to return to work thereby precluding the possibility of trying to return to work and failing at it, or suffering further injury, in cases where both are unconsciously dreaded by the injured worker. Or, extended disability may ensure that the injured worker gets a form of support from family members that serves to replace the respect they once commanded as the breadwinner in the family. As a description of a cause of a disability, it may establish compensability.

“DDD” refers to degenerative disc disease, a gradually worsening back condition which is present in most people as a result of aging but is aggravated or made disabling by injury and by hard physical work.

6.2 The Evidence on File

In an appeal involving a medico-legal issue you will usually be attacking a decision that is based on the opinion of a Board doctor. You will need to develop arguments which affect the weight to be given to the medical evidence on file. This section will discuss where to find the Board doctor's opinion and will review a number of common factors that affect the weight to be given to Board doctors' opinions. Most of these factors apply equally to company doctors' opinions, including examinations done pursuant to s.36 of the Act.

In October 2005, the Board produced an Adjudication Support document entitled “Best Approaches: Weighing of Medical Evidence”⁸ which addresses some of the Board's shortcomings in weighing medical evidence. These are discussed below in Section 6.2.3. For example, the Board acknowledges the importance of the attending physician's knowledge of the injured worker, and the fact that a treating doctor is able to evaluate the worker's genuineness and the reliability of the worker's description of symptoms and ongoing impairment. The document also directs adjudicators to consider the expertise of the doctor and whether there is supporting medical literature. It directs adjudicators to frame their questions to the Board's medical consultant in an objective and unbiased way and to refrain from offering their lay opinion. Decision-makers are instructed to identify evidence that is not accepted or is given less weight, and to give reasons for their assessment of relative weight. All these are points that representatives need to address in arguing a case.

6.2.1 Where to Find a Board Doctor's Opinion

The first task is often to find the Board doctor's opinion in the Board file. It may consist of only a word or two. Comments such as “agree”, “agree deny”, “deny”, “medically reasonable”, scrawled cryptically at the bottom of a memo, are often the only evidence of a medical opinion on file from a Board doctor. As well as reviewing the relevant documents in the medical section of the file, it is necessary to carefully scrutinize the memo section. For example, in the case of a pension rating or a decision on entitlement to compensation for psychological disability, there may be corresponding medical opinions in the medical section and the memo section, depending on the dates when the assessments were conducted. (See Chapter 4: The Board File, Section 2 for more detail.)

In addition to using numbered memos, Board doctors may respond to questions from adjudication staff by simply writing at the end of the referral memo or in the margins. The Board's understanding of what its doctor is saying is as important as the opinion itself and may be revealed in the adjudication memos or the correspondence. Essentially, there are no shortcuts. You should review the entire file.

6.2.2 When the Board Doctor Has Given a Legal Opinion, Not a Medical One

It is really a misnomer to refer to the “agree deny” style notations by Board doctors as medical opinions or reports. If a doctor came to the appeal hearing, grunted “agree deny” and left, the opinion would be given minimal weight if not completely ridiculed. It should be given no more respect just because it is on paper.

Opinions about whether or not a condition is compensable or a claim should be denied are not within the Board doctor’s expertise or jurisdiction. Technically, it can be argued that such opinions should be ignored. In reality, these opinions will probably not be “read out” of the file, however, their influence can be minimized. Representatives should emphasize that the only relevant opinions of a Board doctor are those dealing with medical questions such as the existence or level of disability, or the relationship of the disability to the original injury or work process.

6.2.3 Factors Affecting the Weight of the Board’s Medical Opinion

6.2.3.1 When the Board Doctor Has Not Given the Basis for the Opinion

A credible medical opinion gives the history on which it is based and the physical findings on examination, and explains the process through which the doctor has applied medical knowledge and experience to the history and findings in order to arrive at some conclusion. Board doctors doing a paper review should state their understanding of the history and the relevant physical findings which are accepted or disputed.

The adjudicator’s decision should not simply defer to the Board doctor but must assess the weight to be given to the doctor’s conclusions. If crucial information is lacking from the Board doctor’s “report”, there is less reason to give the report any weight. If the Board doctor has simply stated a conclusion without any information to evaluate the basis or strength of that conclusion, there is arguably no reason to give it any weight at all. Often adjudicators will indicate the answer they are expecting in their memo to the Board doctor. Such “leading questions” should diminish the weight given to the Board doctor’s opinion.

In WSIAT Decision 3034/00 (28 December 2000), the vice-chair did not accept the opinion of the Board doctors that the condition was not related to the compensable injury because they had apparently relied on a Tribunal discussion paper as predetermining the issue. In WSIAT Decision 321/00 (7 February 2000), the vice-chair stated that unless there are detailed medical opinions, rather than adjudicative statements to the contrary from Board doctors, the medical input on employability provided by the family doctor and/or the treating specialist could not be ignored by an adjudicator. The panel in WSIAT Decision 1444/99 (2 November 1999) accepted the opinion of two experts over that of the Board’s occupational disease consultant, and concluded that the workplace exposure was a significant contributing factor in the development of malignant hyperthermia and related symptoms. The specialists’ opinions were more comprehensive than the opinion of the Board doctor who offered no explanation or rationale for his views.

6.2.3.2 When the Board Doctor Has Not Examined the Injured Worker

In most cases, Board doctors have not examined the injured worker. This significantly affects the reliability of their medical opinion, especially where the issue is whether the injured worker is still disabled. A treating doctor who has examined the injured worker and has reported ongoing disability is in a better position to know the actual condition of the worker.

On occasion, the Board will require an injured worker to be examined by a Board doctor or a consultant hired by the Board (for example, if regular progress reports do not show any significant change in the worker's condition over a prolonged period when the Board expected improvement). This goes part way to address the criticism of a medical report based only on a paper review of the worker's file. Again, the treating doctor is always in a better position to know the injured worker's condition and a single examination by a Board doctor does not provide the same level of understanding. The treating doctor is usually familiar with the worker's pre-accident condition, is fully aware of how the injury occurred, and has followed the disability from its onset through regular examinations. All of these factors enable the treating doctor to make a more reliable assessment of the injured worker.

In WCAT Decision 41, the panel preferred the opinion of the injured worker's treating doctor over the contrary opinion of the Board doctor for several reasons, including the fact that the treating doctor had been solely responsible for the care and treatment of the worker's condition.⁹ In Decision 102, the panel expressed a similar preference, noting that the Board doctors had not examined the injured worker.¹⁰ Similarly, in WSIAT Decision 3034/00, the vice-chair decided to prefer the opinion of the treating specialist over the Board's doctors and a Tribunal medical discussion paper.¹¹ The specialist had treated the worker over a period of five years and, therefore, was in the best position to assess the worker's condition and its origins. As well, as a specialist, he would be particularly aware of the differing medical views with respect to symptoms in the worker's opposite leg and would have weighed those views in arriving at his conclusions.

6.2.3.3 When the Injury or Accident Has Been Misunderstood

Often a minimal or inaccurate description of the accident in the file has led the Board doctor to expect the disability to be less serious or of shorter duration than is actually the case. Board doctors appear to rely heavily on the referral memo and on earlier memos that summarize the case. On closer scrutiny, these memos often understate the accident or the original level of disability.

For example, in one case the injured worker was said to have "slipped on some stairs". In fact, the worker was carrying a heavy steel bar off a roof in the rain when he slipped on the top step of a metal staircase and went down the entire flight, on his back, with the steel on top of him. In another case, the injured worker was said to have been in his crane while it was bumped by another crane. In fact, he was operating his crane when it was struck by another one travelling at full speed and both were substantially destroyed by the impact.

More weight should be given to the opinion of a doctor, such as the treating doctor, who is completely familiar with the original accident. In WSIAT Decision 1236/00 (18 August 2000), there were conflicting reports from Board doctors as to the relationship between the accident and the herniated disc. The panel accepted the supportive evidence and found that the accident was a significant contributing factor to the herniated disc. The unsupportive evidence was based on an

incorrect understanding that the accident was trivial. Similarly, in Decision 1712/99 (28 June 2000), the panel found that the injured worker's job involved a considerable amount of lifting, greater than demanded by activities of daily living and greater than Board doctors had understood the case to be when they provided their opinions.

In WCAT Decision 41, the panel preferred the opinion of the injured worker's doctor over the contrary opinion of the Board doctor. The panel noted that the Board doctor relied on a significant understatement in the file of the accident and of the degree of emotional and physical stress experienced by the injured worker. The injured worker's doctor provided a clear and rational explanation of the relationship between the injury and the accident.¹²

The same considerations with respect to the weight of the medical opinion apply to the description of the original injury. For example, the term "back strain" can encompass a range of conditions from minor discomfort to severe permanent disability. It is important to have an accurate picture of the injured worker and their disability at the relevant time. While the treating doctor usually has this, the Board doctor may be misled or misinformed by the file.

In WCAT Decision 50, the panel felt that the Board doctor's note that "the worker did go back to work but was not able to work for more than two or three hours" was significant because it did not mention the injured worker's experience of pain at a disabling level associated with the movement required for the job. They concluded that the Board's medical account of the worker's disability was deficient in failing to take account of her symptoms.¹³

In WSIAT Decision 35/04 (28 January 2004), the opinion of the Board doctors, that the worker's asthma was not related to exposure to sensitizers at work, was based on the assumption that symptoms did not arise until the summer of 1994. However, the vice-chair was satisfied that the first symptoms arose while the worker was working in the fall of 1993 and accepted the injured worker's supporting medical opinion. In WSIAT Decision 1604/97 (8 June 2001), the panel decided not to accept the opinion of the Board doctors who had assessed the worker because that assessment occurred at a very early stage in the worker's history of symptoms.

The panel in Decision 1200/99 (2 September 1999) noted that all the worker's treating doctors attributed the development of his left lateral epicondylitis to his work duties. The Board doctor was of the opinion that there was no relationship between the worker's employment and his left tennis elbow, having focused only on the reaching required in the job but not the gripping, pushing, and pulling against resistance. The panel preferred the opinions of the worker's treating doctors because they were more fully aware of the physical demands of his job.

6.2.3.4 When the Board Doctor is Not as Well Qualified as the Worker's Doctor

As mentioned earlier, the doctor's qualifications and experience are also relevant to the weight to be given to their evidence. The medical school, year of graduation, specialty, and current practice of all physicians are listed in the Canadian Medical Directory (see Appendix 5-A). This information can also be obtained from the College of Physicians and Surgeons. When conflicting medical opinions are at the root of your appeal, you should ask your medical experts to state their background in their reports. The WSIAT now requests that the doctor's *curriculum vitae* accompany any new medical report provided after the commencement of an appeal.

In the past, the Board has released biographical information about Board doctors on request. In some cases, the "Board doctor" is not a doctor at all and the section medical advisor may be a

nurse. Often you will find that Board doctors, even if they are doctors, are not specialists or they offer opinions on something outside of their expertise. For example, a gynecologist's opinion on a back injury should not be given the same weight as the opinion of the worker's treating orthopedic surgeon or physiatrist. It should be argued that the opinion of a doctor with 30 years of clinical experience should be preferred over that of a relatively "green" Board doctor or one whose experience has been mostly in government bureaucracies. A general practitioner with a special interest in occupational health issues or specialized clinical experience is preferable to a Board general practitioner.

In WCAT Decision 102, the panel accepted the medical opinions submitted by the injured worker because the doctors providing these opinions were specialists in the relevant field while the Board doctors involved were not, and had not examined the injured worker.¹⁴

6.3 The Use of New Evidence

It is important to critically review the medical evidence in support of a claim, as well as the evidence against it, with an eye to the following questions:

- Is any important basic data missing, such as dates of visits with doctors, physiotherapists, or chiropractors?
- Does the doctor who gave a supportive opinion have an accurate history?
- Has the doctor recorded appropriate examination findings and made a diagnosis?
- Has the doctor's opinion been expressed cogently and clearly?
- Even if the supportive opinion(s) have all of these features, is there such substantial weight from the negative evidence on file that a further supportive opinion might significantly improve the chances of success?
- Is additional medical evidence needed to support the payment of further benefits in the event that the claims adjudicator, ARO, or Tribunal agrees with the worker on the medical issue in dispute?

New evidence may come from the worker's family physician or specialist, or from an independent referral to an occupational health clinic or to a new specialist. Some specialists will take a direct referral from a representative; others require a referral from the worker's family physician and, from time to time, it is necessary to discuss these referrals with the worker's family physician.

6.3.1 To Overcome the Weight Given to Board Doctors' Opinions

Sometimes a new medical report can be useful in overcoming the weight given to the opinions of Board doctors. For example, the worker's family doctor could be on record as confirming a permanent disability and the Board doctor on record as disagreeing. You might believe that the evidence for and against is approximately equal, and hence that s.119(2) of the Act requires the issue to be resolved in favour of the injured worker. But if the ARO sends the file to a Board doctor for a post-hearing opinion, you will have two against one and s.119(2) may not save the

case. If the evidence is approximately equal before the appeal, and you have time to wait for it, a confirming report from a specialist may help tip the balance.

In WSIAT Decision 1846/99 (8 November 1999), a Board doctor provided evidence that the worker suffered a minor twisting injury that should not have resulted in any continuing pain. However, the worker's treating doctors provided evidence of continuous and consistent pain relating to the accident. The vice-chair decided the evidence was approximately equal in weight, applied the benefit of doubt in favour of the worker and allowed entitlement to benefits for chronic pain.

6.3.2 To Oblige the Board's Bias in Favour of Specialists

In some cases, there may be no specialist's report on file. The Board has a bias in favour of specialists which often results in denial until a specialist confirms what the family doctor has been saying all along. The family doctor may not have felt that referral to a specialist was necessary for the purpose of diagnosis or treatment. However, a referral can be arranged by the family doctor if you explain how it could resolve the patient's workers' compensation dispute. Also, the worker's very engagement in the process of referral to specialists and further tests or investigations can be treated as a medical rehabilitation program for the purpose of paying full benefits.

6.3.3 To Get a Fresh Look at a Stale Issue

In some cases, the medical evidence on file is contradictory and years old by the time you get the case. Although there is little possibility of anything new being said, you may want to send a copy of the relevant parts of the medical section of the Board file to the specialist of your choice to obtain an opinion about the evidence in support of your claim. At the very least, a supportive new report will provide something new that a sympathetic ARO or WSIAT panel or vice-chair can seize on as a reason for allowing the appeal. More recent developments in diagnostic techniques or appreciation of work-relatedness can sometimes shed new light on an old problem. Also, on occasion, a serious injury will show up later in degenerative changes set in motion by the original injury. Later findings may confirm the theory of the case presented earlier when there were fewer objective findings.

6.3.4 To Respond to a Tribunal Medical Assessor

Under s.134 of the Act, the Tribunal maintains a list of health care professionals who may be called upon for assistance to better enable the determination of a question of fact in an appeal. The need for an assessment might be identified by the Tribunal's Medical Liaison Office during a pre-hearing review of the file, or by the panel or vice-chair conducting the hearing. An assessment has also been requested in connection with an application to reconsider a Tribunal decision on the basis of new medical evidence.¹⁵ While the assessment can be a review of the file, it is usually a report based on a personal examination of the injured worker.

This is not an alternative to obtaining all possible supportive medical evidence prior to an appeal. Generally, it is the responsibility of the worker's representative to ensure that sufficient and persuasive medical evidence is on file and that a referral to a Tribunal assessor is not needed. The Tribunal may request an assessment when it feels the file lacks sufficient medical information; for example, if a comprehensive medical evaluation of the worker's condition and

the workplace exposure is not on file,¹⁶ or if it seems appropriate to ensure that the Tribunal does not misinterpret any of the medical evidence.¹⁷

When a panel or vice-chair requests an independent medical assessment, the matter is referred to the Tribunal's Medical Liaison Office. Tribunal staff will draft the referral letter based on the vice-chair's instructions and seek input from the parties. Reasoned and constructive suggestions for modification of the Tribunal's referral letter are generally accepted. The independence of the medical assessor is established through statutory criteria in s.134(5) of the Act which prohibits prior contact. If an injured worker does not co-operate in the assessment, benefits or the right to a decision may be suspended under s.134(8) until the worker co-operates.

In practice, the Tribunal places great weight on the opinions of its medical assessors. It is therefore very important to respond directly if the assessor's report does not support the appeal. It may be possible to challenge the facts relied upon as the basis for the opinion, particularly if the assessor relies on facts inferred from reports on file that were not set out in the referral letter. In order to provide a credible alternative medical hypothesis, you will generally need to have an unfavourable assessor's report reviewed by your own medical expert, preferably one with equal professional credentials who has the additional benefit of having been involved in the worker's treatment.

In Decision 1514/02, the panel was persuaded to accept entitlement despite the Tribunal medical assessor's contrary opinion.¹⁸ The Tribunal assessor's opinion was that the injured worker's heart condition would have developed regardless of the workplace injury. The panel reviewed the medical journal article cited in support of that opinion, and reviewed letters published in subsequent editions of the journal which challenged the article and eventually led to a letter from the researchers of the original article admitting that their findings were not as broad as they first appeared. That left room for an alternative medical theory of the case that was supported by other medical literature and the worker's treating doctor.

7. CONTENTS OF MEDICAL REPORTS: COMMON MEDICAL TESTS AND PROCEDURES

Medical reports should contain the following information:

- examination date(s);
- subjective and objective clinical findings;
- test results;
- diagnosis;
- treatment recommendations; and
- opinion.

It is very common for the opinion section of a report that has not been prepared for medico-legal purposes to not address the issue of causation.

A description of some common objective clinical and diagnostic tests follows.

7.1 Subjective and Objective Findings

In every case, the process of reaching a diagnosis is highly dependent upon the history obtained from the injured worker by the doctor. Through taking the history and examining the patient, the doctor will note a number of “subjective” findings which depend on the injured worker’s senses and the ability and willingness to accurately describe what they are sensing. The most common examples are the responses to questions about where and when it hurts, what kind of pain it is, how severe the pain is, and what relieves the pain. For many disabilities, the diagnosis must be completely or mainly dependent upon the subjective findings made by the doctor.

However, the process of assessing and diagnosing a disability often includes a number of tests designed to yield “objective” findings. While these tests do require the worker’s consent, if not active co-operation, the results are perceptible to the outside observer, usually the person administering the test, as opposed to being perceived and reported by the patient. The most common examples are blood tests and x-rays.

While one needs to be familiar with the types of tests administered in order to effectively review the records of the examination, assessment, and diagnosis, it is also important to inquire further to determine the significance of the test results. For example, you may be dealing with a disability, such as chronic pain or a psychological condition, for which the diagnosis is entirely dependent on subjective findings. If that is the case, then the absence of any objective findings is not evidence that the worker is not disabled.

As well, where a relevant test has not produced a result consistent with the injured worker’s position about the nature or extent of the disability, you will need to enquire about the extent to which test results are dependent on personal characteristics of the injured worker.

You will often see a doctor noting that the worker was unco-operative during a procedure or test. Sometimes, the implication is that the injured worker is malingering or exaggerating. But the fact that the worker was not fully co-operative means only that the results of the test are not reliable; it does not mean that the results are negative or that the worker is malingering. For example, range of movement tests or lung function tests are not reliable if the worker does not actively participate to the extent required. However, often the worker may not participate fully because of a lack of understanding of what is required, because of a fear of causing further injury or pain, or because of anger resulting from the perception of not being believed.

In another example of alleged worker unco-operativeness, the straight leg raising test may have to be aborted if the worker resists movement due to pain before the doctor has raised the leg far enough that pain can be accepted as a positive test result. This is often contrasted in the report with the worker’s ability to flex to a much greater extent when sitting or putting on shoes. One can only conclude, based on such a comparison, that there is no reliable result, not that the worker is dishonest. The worker has already learned through experience which familiar activities such as sitting, and putting on shoes and socks, can still be done without pain or further injury. This must be contrasted with new and potentially harmful activities which require caution and resistance in order to avoid further injury, such as being manipulated on a table by a threatening Board doctor who is trying to find what will reproduce the worst pain.

The interpretation of test results involves complex questions and the answers are beyond the scope of this manual. However, research is necessary when interpreting test results.

What follows is a brief outline of some medical tests commonly used to obtain objective medical findings in the examination and diagnosis of injured workers.

7.2 Orthopedic and Neurological Examination

The orthopedic tests include movements and observations commonly used by that specialty to diagnose, but also to detect lack of effort and malingering.

7.2.1 Back injuries

- **Jugular Compression or Nafziger's Test**
Bilateral jugular vein compression increases spinal fluid pressure which causes an increase in pain. A positive test may indicate a prolapsed disc.
- **Straight Leg Raising (SLR)**
This term is sometimes used interchangeably with positive or negative Lasègue's sign (described below); however, SLR and Lasègue's sign are different procedures. SLR is a common procedure which is often misinterpreted. The patient lies on his or her back while the doctor raises the patient's leg by the ankle and bends it from the hip. If the injured worker's pain is reproduced at a certain point in the raising (after 30 degrees of elevation) then the test is positive. This is an objective diagnostic sign of lumbar disc herniation which creates pain by impinging on the nerve root. It is of greatest value in helping to locate a disc herniation at the L5-S1 and L4-5 levels. A disc herniation at L3 or L4 may not produce a positive SLR. Correct movement and interpretation are important because pain on SLR can also indicate tight hamstring muscles, or pathology of the hip joint or sacroiliac joint.
- **Lasègue's Sign**
This test is done as part of straight leg raising to ascertain whether the origin is the nerve root. In the course of checking straight leg raising, the doctor positions the leg and accompanies this with a movement of the foot which will reproduce the back pain if there is a nerve root problem. A positive Lasègue's sign indicates that nerve root inflammation is causing the pain. If there is no pain the problem may be sacroiliac joint pathology.
- **Sitting Root Test or Sitting SLR**
The patient sits while the doctor extends the patient's lower leg. Sciatic type pain at a particular point during the extension is a positive test indicating lumbo-sacral nerve root compression. The type of pain and point of onset are significant for the diagnosis.
- **Heel Walking**
A neurological test for L4-5 root involvement.
- **Toe Standing**
While repeated elevations will fatigue an involved L5-S1 nerve root, one elevation may not reveal significant weakness even when there is injury. Conversely, weak leg muscles will produce the same effect as nerve root injury.

- **Knee Jerk**
A depressed knee jerk indicates pressure on the L3-4 nerve root, but the knee jerk is not affected if nerve root involvement is at L4-5.
- **Bowstring Sign**
A manipulation of the knee during straight leg raising, which, if positive, reproduces pain in the leg or back. A positive test confirms nerve root compression such as that caused by a ruptured intervertebral disc.
- **Femoral Stretch Test**
A test for nerve root involvement at L2-3, L3-4.
- **Ely's Test**
A manipulation of the leg. A positive test may be an indication of sacroiliac joint pathology.
- **Plantar Response**
Part of the response is lost with L5-S1 nerve injury.
- **Ankle Dorsiflexion**
Weak responses may indicate L4-5 nerve root involvement such as that caused by disc herniation.
- **Quadriceps Weakness**
May result from L3-4 nerve root involvement.

7.2.2 Back and Lower Limb Injuries

- **Hoover Test**
This test is used to detect malingering or submaximal effort. The patient lies on his or her back while the doctor puts both hands under the heels and asks the patient to try to raise one leg. If an effort is being made, the doctor will feel a counter pressure downward on the opposite leg.
- **McMurray's Test**
The leg and foot are manipulated. A painful click indicates a torn knee joint meniscus.
- **Babinski's Sign**
A depressed Achilles tendon reflex is used to distinguish organically caused sciatica from psychologically caused sciatica.
- **Sensory Examination**
A pin is run down the sides of the legs to the toes. A difference in sensation between left and right indicates nerve root involvement. Glove or stocking anesthesia are patterns of numbness with no anatomical basis and are therefore negative as they reveal no left/right difference.

7.2.3 Upper Limb Injuries

- **Finklestein Test**

The hand is manipulated to test for DeQuervain's Disease, a painful form of tenosynovitis that may be caused by wringing, twisting motions with the hands.

7.2.4 Organic vs. Non-organic Basis

- **Waddell Score**

A scoring system of signs of non-organic disability used to distinguish between organic disease and symptoms that are psychologically amplified. A score of 3 or more may indicate non-organic problems and the need for psychological assessment. The goal of the testing is not to identify malingerers or exaggerators, but to identify patients who may benefit from psychological or psychiatric treatment and, thereby, possibly avoid risky surgery.

- **Cogwheel Weakness**

A jerky, give-way kind of weakness on testing muscle strength which indicates an emotional rather than an organic basis for that response.

7.3 Non-invasive Tests

Non-invasive tests are mechanical procedures requiring only passive participation by the injured worker.

- **CAT Scan or Computerized Axial Tomography**

Known also as Computerized Transverse Tomography (CTT) or Computerized Tomography (CT), this is a special computer enhanced x-ray process that shows much greater detail of bones and, to a limited extent, of soft tissue.

- **MRI or Magnetic Resonance Imaging**

Also known as nuclear magnetic resonance (NMR), this process performs an analogous function to the CAT scan, but is based on a different principle that does not use radiation. A computer generated image is produced which shows bone and soft tissue distinctly.

- **EMG or Electromyography**

Muscle activity in response to different stimuli is recorded and studied through the use of electrodes which detect electrical responses in the body. In some cases the electrodes are needles which are inserted into the skin, while in other cases they are surface electrodes. The test identifies the nerve involved. Note that since damage to a nerve does not occur for 19 to 21 days after nerve compression, an early test has limited value.

- **X-ray**

A picture of bone and other dense material produced by the shadow of x-rays which pass through skin and muscle, but not bone.

- **Thermography**

A colour picture of the body is produced by the measurement of skin temperature. A significant difference in temperature generally confirms that there is a physical problem, but cannot define the type or extent. This test is controversial and not necessarily accepted by all members of the medical profession.

- **Nerve Conduction Studies**
Electrodes are used to detect the interruption or slowing down of nerve impulses along a nerve.
- **SEP or Somatosensory Evoked Potentials**
Monitors on the head read electrical signals in the brain produced in response to movement in other parts of the body.

7.4 Invasive Tests

Invasive procedures are surgical.

- **Arthrogram**
A picture of the inside of a joint is obtained by injecting dye into the joint and taking an x-ray.
- **Arthroscopy**
The interior of a joint is observed through a flexible tube-like instrument which is inserted into the joint and has a telescopic eye piece or is connected to a video camera. The term “arthroscopy” also includes surgical repair of a joint done with the aid of this procedure.
- **Discogram**
Abnormalities in a spinal disc are detected by injecting dye into the disc and taking an x-ray picture of it.
- **Myelogram**
Spinal disc protrusion or abnormal bone contour is detected by injecting dye into the dural sac (the sheath that surrounds the spinal cord) and taking an x-ray. Adverse effects can result from this procedure or the dye used. It is now known that some dyes used in the past were harmful and were not completely removed after the x-ray. Currently water-soluble dyes are used and not removed.
- **Tenogram**
A picture of the tendon sheath is obtained by injecting dye into the sheath and taking an x-ray.
- **Bone Scan**
A picture of inflammation or damage in bone, and of major active inflammation in soft tissue, is obtained by injecting dye into a vein in the arm and taking x-rays. Active inflammation is indicated wherever there is increased uptake or accumulation of the dye.
- **Nerve Blocks**
When it is difficult to tell which spinal nerve root is causing pain, one nerve root after another is injected with a local anesthetic to temporarily deaden the nerve. When the freezing of a root causes the pain to stop, the location of the pain message is identified. However, this procedure does not identify the cause or extent of the disability.

- **Epidural Venogram**

Analogous to a myelogram, dye is injected into the veins that run inside the spinal canal and an x-ray is taken to observe the flow of the dye. Any blockage in the flow would indicate a bulging disc.

- **Biopsy**

The removal and examination of tissue for the purpose of diagnosis. It is generally done surgically, although in some areas of the body sample tissue may be removed with a needle.

- **Joint Aspiration**

Using a needle, fluid is removed from a joint for examination in order to make a diagnosis, relieve pain, or make room for medication.

8. PROTOCOL REGARDING DOCTORS' REPORTS

8.1 Ownership of Reports

Until recently, many doctors believed they retained ownership of the reports they wrote. Some medical reports are stamped with words to the effect that they are for the recipient only and not to be reproduced or used by anyone else.

In *McInerney v. MacDonald*,¹⁹ the Supreme Court of Canada confirmed that, in the absence of legislation, a patient is entitled to examine and copy all information in the medical records considered in the course of the doctor-patient relationship, including reports prepared by other doctors. The physical records belong to the doctor, but the patient, and therefore the patient's authorized representative, can copy them. This right is not absolute. If the doctor reasonably believes that there is a significant likelihood of a substantial adverse effect on the patient's physical, mental, or emotional health, or of harm to a third party, then the doctor retains discretion to refuse a request for access.

It is now clear that, with the above qualification, patients have the right to complete access to all medical information and representatives, acting on behalf of patients, can obtain the information and send it anywhere. When requesting copies of any reports on file, it is a courtesy, if not a necessity, to briefly explain your role and the intended use of the report, keeping in mind the considerations discussed in Section 9 below.

8.2 Consent to Disclose Personal Health Information

Disclosure of personal health information is governed by the *Personal Health Information Protection Act, 2004*²⁰ (PHIPA). No longer do different rules apply to how health care professionals provide specific kinds of information, such as mental health records. The Regulation under the Act does not prescribe any particular forms for the release of personal health information.

The Ministry of Health and Long-Term Care provides a sample Consent to Disclose Personal Health Information form, as well as other forms, online at www.health.gov.on.ca/english/providers/legislation/priv_legislation/sample_consent.html.

This sample form contains elements that were not found in many pre-PHIPA consent forms. For example, it requires naming the person who is being requested to disclose, stating that the consenting party understands the purpose of the request and knows he or she can refuse to sign it, having someone witness the signing of the form, and providing the name, address, and telephone number of the witness.

8.3 Digging Up a Good Report From a Dead Doctor

The College of Physicians and Surgeons attempts to keep accurate records of the location of patients' records held by doctors who have retired or died. The College may be able to direct you to a family member or colleague who has the records. As noted in the College's policy on medical records,²¹ O.Reg. 241/94, s.19, states:

- 19 (1) A member shall retain the records required by regulation for at least ten years after the date of the last entry in the record, or until ten years after the day on which the patient reached or would have reached the age of eighteen years, or until the member ceases to practise medicine, whichever occurs first, subject to subsection (2).
- (2) For records of family medicine and primary care, a member who ceases to practise medicine shall,
 - (a) transfer them to a member with the same address and telephone number; or
 - (b) notify each patient that the records will be destroyed two years after the notification and that the patient may obtain the records or have the member transfer the records to another physician within the two years.²²

8.4 Burying a Bad Report From a Doctor

You are not under any obligation to submit all reports, whether or not they support your theory of the case. If you receive a report that is not supportive or one that is contradictory, you may want to re-evaluate the strength of your case and the possibility of a down-side risk in the final outcome. However, you are not obligated to submit the report, although the investigatory powers of the Board and WSIAT allow them to inquire about the existence of medical evidence not on file. The role of an advocate is to prepare the best case for the appeal, not to undermine it. To do this, you might obtain several medical opinions and proceed on the basis of the strongest ones.

For this reason, it is routine to request that a medical report be sent to you alone, for the purpose of considering an appeal, and not to the Board. You may be asked by an ARO or a WSIAT vice-chair whether you are aware of any medical opinions or assessments that are not on file. In that case you will need to evaluate whether refusing to answer the question or to provide the reports would do more harm than discussing the non-supportive report. In addition, lawyer advocates should consider the implications of Rule 4.01 of the *Rules of Professional Conduct*²³ in requiring lawyers to treat tribunals with "candour" and "fairness".

8.5 Hospitals and OHIP

Hospital records are often kept indefinitely although not required by law to be kept for any particular period. Usually a standard search and photocopy fee is charged which may amount to well over \$100. Admitting records, for example, may be crucial where a worker claims that a

particular part of the body was injured in the original accident. If there was no ongoing treatment, it may not show up in the notes of the family doctor.

OHIP has records of doctors' billing for services. These billing records can also be obtained to verify treatment of a certain type on a certain date if the dates are not available from the doctor.

9. REQUESTING A MEDICAL REPORT

9.1 General Considerations

Gathering all relevant facts and assembling supportive evidence requires some preparation and planning, beginning with obtaining a medical report. A very informative article on this subject, "The Medico-Legal Report: Obligations and Rights", was produced by the Medico-Legal Society of Toronto.²⁴ It gives a number of practical suggestions, including an outline of how to request a medical report and some guidelines for doctors to use in the preparation of medico-legal reports. In particular, the article alerts readers to relevant sections of the Canadian Medical Association Code of Ethics adopted by the Council of the College of Physicians and Surgeons of Ontario.²⁵

The Code of Ethics is useful in understanding doctors' responsibilities and you should consider obtaining a copy if you will be dealing with doctors on a regular basis. For example, paragraph 9 of the Code of Ethics is quoted in the article referred to above:

Where there is an obligation for a physician to produce a medico-legal report, there is an obligation to provide a professionally proper report. Among other things, such a report supplies the information required to enable the patient to receive any benefits to which the patient may be entitled.

Your letter of request for a medical report should be at least as thoughtful as the response you would like to obtain. Simple requests for "an up-to-date report" are unlikely to elicit a useful reply, unless you have previously obtained a detailed report from the doctor and all you actually require is an update.

When requesting a medical report, there are no hard and fast rules, but there are a number of considerations that can guide you. Explain everything that is necessary clearly and concisely, beginning with the purpose of your letter. Tailor your letter to the issue at hand. In most cases, try to keep it short — one or two pages at most. (Although in occupational disease cases, where it is necessary to include factual background information, the letter may be longer (see Chapter 8: Occupational Disease, Appendix 8-E, for a sample of such a letter).)

AROs and the WSIAT often request that copies of the letter to the doctor be submitted with copies of the report. You should be striving to write a request that you could disclose without fear of criticism: one that restricts the response to the narrow medical issue and shows what needs to be addressed if the injured worker's case is to be supported. The same principles apply when writing to any health care professional, not just specialists.

EXAMPLE:

Dear Dr. X:

Re: Ms. B.

Our clinic is representing Ms. B. in her claim with the Workplace Safety and Insurance Board. As you may know, the Board has refused to recognize her asthma on the basis that it is not believed to be related to exposure to chemicals at work. I am preparing for an appeal hearing and would appreciate receiving a report from you on the following issues that could be submitted with our appeal. This would not require your attendance at a hearing.

With an opening like this, the doctor knows to what extent he or she is being asked to participate, what the problem is with the Board, and what the representative is doing.

In the majority of cases, your client will already have been diagnosed and the medical issues will be related to either the causal connection between the work and the condition, or the identification of the extent of the disability. It is important to restrict your letter and the doctor's response to the relevant medical issues.

If a doctor is interested in peripheral details such as compensation benefits or the level of appeal, they can ask you. Work-relatedness and level of disability are medico-legal issues. Entitlement and level of benefits are legal issues that follow the establishment of the medical facts and mentioning them can trigger personal, non-medical reactions that could taint the report.

You should always ask doctors clear and specific questions to assist them to focus on the relevant medical issue. In some cases, it can be effective to highlight the questions in your letter so that they stand out.

EXAMPLE:

Instead of asking:

Please comment on whether Mr. X was still disabled by the surgical repair of his hernia after September 1st.

You should ask:

As you know, Mr. X works at the van assembly plant. For the past five years he has been on the production line, lifting wheel-tire assemblies (weighing approx. 35 lb. each) to waist height, stabilizing them with his left hand and knee while bolting them on with a 10 lb. power tool in his right hand at a rate of about 30 repetitions per hour. Could you please comment on the following:

- On September 1st, was Mr. X fit to return to his regular job at the van assembly plant?
- If not, what restrictions regarding the hours of work and activities of work (such as standing, sitting, bending, lifting, pushing, pulling, and rest periods) would, in

your opinion, have been suitable to enable him to return to some form of employment during the months of September and October?

These rules are not carved in stone. As a representative, your role is to lay out enough facts so that the doctor has a clear idea of the situation.

EXAMPLE:

As you may know, Ms. B. has been denied any further assistance from the Board on the basis that she is now able to return to her regular job as a quality control inspector. She advises me that she cannot do this because prolonged exposure to the fumes in the plant, described below, triggers asthma attacks.

9.2 The Family Doctor's Report

The family (or treating) doctor is in the best position to know an injured worker's pre-accident abilities, the nature of the injury, and post-accident abilities. However, the Board tends to show little respect for the opinion of the family doctor if one of its own doctors holds a different opinion. In many cases, a report from the family doctor would not be sufficient to reverse a Board decision.

If your client has seen a specialist, you can request the worker's family doctor to provide you with a copy of the specialist's reports on file. Along with this request, you can consider writing for a specific medico-legal opinion from the specialist or simply rely on the existing consultation notes. If the medical issue is difficult to understand, you might just want the family doctor to call you and discuss the points of concern before you write to the specialist. If the issue is whether a particular type of work is suitable, you may want to write a detailed explanation and series of questions in order to elicit a detailed written response.

9.3 The Specialist's Report

When a supporting medical opinion is crucial, it is most often sought from a specialist. You should do sufficient research in the medical literature, the Act, Board policies, and WSIAT decisions to know the opinion that you are hoping the specialist will give. Your job as a representative is to focus and control the answers in the report by controlling the medical questions. Obviously, this must be approached with integrity. You cannot omit or misrepresent relevant facts that you fear could weaken support for your client's position. Nor should you push to the extent of putting words in the mouth of the specialist.

10. PARTICULAR MEDICAL QUESTIONS IN COMPENSATION

10.1 General Considerations

As discussed earlier, you will be more successful obtaining a supportive medical opinion by controlling the medical questions. This requires some medical research and the development of a medico-legal theory of the case. There is no one right way to do this. In this section, some common approaches used in workers' compensation problems are discussed to give examples of the considerations involved.

10.2 Fitness to Return to Work

The current approach of the WSIB is to return injured workers to regular or modified employment as soon as possible after the workplace injury. (See Chapter 18: Early and Safe Return to Work and Labour Market Re-Entry.) In most cases, if the Board accepts that the employer has offered suitable work at no wage loss, the worker's benefits will be terminated, whether or not the worker feels able to do the job offered.

If the worker feels that a job being offered is medically unsuitable, this job should be described in great detail in your letter to the doctor. Include a written job description (assuming the worker agrees with the details) and a Physical Demands Analysis, if these are available from the employer. If not, write them yourself based on the worker's description of the work. If the employer and the worker have differing versions of the job in question, include both versions in your letter. In your letter to the doctor, you should ask:

- Is the worker capable of working?
- If so, are there limits on the nature and hours of work?
- Is the work being offered within the worker's limitations, if any?

10.3 Causation and Work Relatedness

In many cases, a question arises of whether or not the disability was caused by the work and is therefore compensable. For example, in occupational disease and repetitive strain cases, representatives consider "caused by" to be a euphemism for a much more complicated question about entitlement under the Act. As discussed in Chapter 7, Entitlement Issues, the real question is whether or not it can be said that the work probably made a significant contribution to the development of the disability.

However, in seeking a supporting medical opinion, you are approaching an expert with a scientific background who draws conclusions on the basis of scientific certainty, not the balance of probabilities. It is likely that the doctor is also under the misconception that a clear cause and effect relationship is needed for the worker to be entitled to workers' compensation. You may have a worker who smoked a pack of cigarettes per day and had five years sporadic exposure to asbestos 20 years before he died of lung cancer. If you ask whether the asbestos caused the lung cancer, you may well get a "No". Yet the lung cancer may be compensable because the asbestos probably made a significant contribution to its development, although not as significant a contribution as smoking. Again, this confirms the importance of doing the research, developing a theory of the case, and carefully considering the issues and the evidence you need, *before* you start requesting expert

opinions. Consider the following approach which borrows from the Tribunal's causation jurisprudence, such as that found in Decision 2747/00 and older decisions, such as Decisions 72 and 280.²⁶

EXAMPLE:

The Board has not recognized a relationship between her workplace exposure to asbestos and the development of lung cancer. We therefore require your opinion on the issue of whether the asbestos made a significant contribution to the development of her lung cancer.

A number of important qualifiers apply to this question within the context of workers' compensation:

- First of all, it is not necessary for asbestos to be the only cause of the lung cancer, or even the most significant cause. It is sufficient if it is established that asbestos was one significant contributing factor.
- Second, by "significant" we do not mean quantifiable in any particular statistical or numerical sense but in its common usage or dictionary meaning. A contributing factor is considered significant if it is of considerable effect or importance or if it added to a pre-existing condition or another contributing factor in a material way.
- Third, the question must be answered on the balance of probabilities, on a probably/probably not basis, rather than treated as requiring certain proof.

On this basis, please explain whether, in your opinion, the asbestos exposure described above would probably or probably not have made a significant contribution to the development of her lung cancer.

This example shows the value of explaining worker's compensation principles. It also indicates that you do not need to look for a stronger case than required by law. (See Chapter 7: Entitlement Issues, Section 3 for a detailed review of causation principles.)

10.4 Pre-existing Conditions

In some cases, the ongoing disability is not caused strictly by the compensable injury. For example, in back injuries, many workers who never recover are diagnosed as suffering from degenerative disc disease. If you ask the doctor whether that condition is caused by the compensable accident, the answer will be "No". It is generally considered a natural consequence of aging.

However, if you ask the right questions, you may ascertain that the severity of the symptoms is not directly related to the extent of degeneration, that the worker was symptom-free before the accident, and that the accident probably caused the previously asymptomatic degeneration to become symptomatic and very disabling. For example, you could ask:

- Did the patient have any complaints or symptoms of back disability before the accident?

- Do some people display x-ray evidence of degenerative disc disease although they are symptom- and accident-free?
- Can a significant degenerative disc disease that has few, if any, associated complaints be rendered significantly disabling as a result of trauma?
- Are the history and findings in this case consistent with a previously asymptomatic degenerative disc disease being rendered disabling by sudden workplace trauma?

On the basis of these questions, you can establish entitlement to compensation. Again, this demonstrates the importance of doing the medical research, developing a medico-legal theory of the case, and then getting the expert evidence needed to support the argument. (See Chapter 7: Entitlement Issues, Section 3.6 for a discussion of the policy and law on pre-existing conditions.)

11. DOCTORS AS EXPERT WITNESSES AT HEARINGS

11.1 Board / WSIAT Policy and Practice

Although there are provisions for summoning doctors as witnesses, both the Board and Tribunal generally decline representatives' requests to summons a medical witness. The reason generally given is that there is ample medical evidence on file and/or that any further medical opinion can be presented by a written report without the doctor having to take time away from their practice, thereby avoiding the need for additional hearing time and scheduling difficulties. For example, the Tribunal's Appeal Procedures document states:

Please note that the Tribunal prefers to rely on written reports from expert witnesses. Oral testimony is seldom necessary, unless a report requires additional clarification.

While that may be true, the attendance of the treating doctor has a very powerful impact and it may be worthwhile to bring the doctor even against the wishes of the Board or Tribunal. It is rare that you would need to bring a doctor as a witness, but when a doctor does attend and give evidence, it is usually accepted as the basis for allowing the appeal. If an important compensation issue hinges on a medical issue, it can be wise to do everything possible to convince the family doctor or treating specialist to give evidence in person. Sometimes a doctor's reluctance is due to a misconception that the hearing process will be very adversarial, or will be a forum to impugn their credibility, or will require them to sit around waiting all day. It may be necessary to pay the doctor an attendance fee to make up for lost income while away from the office. Even if the Board or Tribunal agrees to pay its standard expert witness fee, a doctor may require an additional amount.

It is virtually impossible to have Board doctors attend a hearing and give evidence. They will not willingly attend and the Appeals Branch refuses to summons them. This refusal is based on the Appeals Branch's interpretation of s.131 of the Act, the right of the Board to determine its own practice and procedure, and s.180 regarding the non-compellability of Board employees in a court or tribunal proceeding. The WSIAT has determined that it cannot consider an appeal from such a decision because it does not have jurisdiction to do so.²⁷

The WSIAT has determined that it does have jurisdiction to summons Board doctors and compel them to give evidence. However, it has also determined that, under s.181, the Board has the final

say as to whether it will consent to the release of information by a Board doctor or any other Board staff member who is under subpoena.²⁸ This effectively neutralizes the power to summons Board staff. Therefore, a refusal to summons a Board doctor would have to be reviewed by the Ombudsman or the Superior Court in an application for judicial review.

11.2 Examination of Doctors

Considerations relating to the examination of doctors are discussed in Chapter 3: System of Review and Appeal, Section 3.5.4.

12. COMPLAINTS ABOUT DOCTORS AND OTHER HEALTH PROFESSIONALS

A client might ask you for advice regarding a problem with a treating doctor. Representatives can advise the worker about the right to pursue a complaint about a Board or a company doctor. Most health care professions are self-regulated under the RHPA²⁹ as discussed in Sections 4.1 and 5.1 above. Under the RHPA, the College of Physicians and Surgeons of Ontario licenses physicians, oversees their professional conduct, and regulates the practice of medicine.

Complaints about physicians are made in writing to the Registrar of the College of Physicians and Surgeons of Ontario. A complaint may go through a resolution process which could solve the problem prior to an investigation. If the pre-investigation attempt at resolution is not successful, an investigation is carried out, and the complainant is informed of the results once the investigation is complete.

If the complainant's concerns are still unresolved, all of the information collected by the College is sent to its Complaints Committee. This Committee is appointed by the College and is composed of six doctors and three non-doctors. The Committee reviews the written material and decides if there is *prima facie* evidence of professional misconduct. The term "professional misconduct" is defined at considerable length in O.Reg. 856/93, amended by O.Reg. 53/95, made under the *Medicine Act, 1991*.³⁰ It includes failing, without reasonable cause, to provide the patient or the patient's authorized representative with a report related to an examination or treatment performed by the member within a reasonable time.

If the Committee decides that such *prima facie* evidence exists, it refers specified allegations to the College's Discipline Committee and notifies the complainant in writing of its decision with reasons. If the complaint is dismissed by the Complaints Committee, the complainant can appeal to the Health Professions Appeal and Review Board (HPARB) within 30 days pursuant to s.29(3) of the Health Professions Procedural Code.³¹

The HPARB is made up of 12 to 20 non-doctors who are appointed by the Ontario government. In reviewing the dismissal of a complaint, the HPARB holds an informal private hearing where evidence is not sworn and no record is made. It can uphold the dismissal of the complaint or refer it to the Discipline Committee. The Discipline Committee can find the doctor not guilty, reprimand the doctor, impose a fine, or suspend or revoke the doctor's licence to practice under RHPA.

The same complaint processes apply to all 22 self-governing health care professions under the RHPA.

13. MEDICAL RESOURCES

13.1 Specialized Health Clinics

Most often, a case is presented on the basis of reports from treating doctors. Generally, it is the family doctor who directs referrals to specialists. But in some cases, you will want to make your own referral to a doctor with relevant expertise for the purpose of obtaining a medico-legal report in support of the claim. Appendix 5-B lists health clinics and hospitals to which representatives can make referrals. In addition, some community health centres and hospitals have staff with expertise in occupational health matters.

13.2 Researching the Medical Literature

13.2.1 Research Resources

It is useful to have ready access to some medical textbooks for reference at your office. Appendix 5-A lists publications that would form a minimal office library and then lists several more that would constitute a good office library.

A number of well-equipped libraries are available in Toronto. The Office of the Worker Adviser, the Board, the Ontario Federation of Labour, and the WSIAT all have good libraries that are open to the public and have helpful staff. All medical schools have extensive libraries, and most universities and colleges have some relevant material. Hospitals, community health centres, and the Occupational Health Clinics for Ontario Workers (OHCOW) all have their own libraries which, although not public, may be accessed by special arrangement. Some medical school libraries will locate and photocopy relevant journal and text entries for a fee. You may be able to obtain this form of assistance on an occasional basis from a community health centre or an OHCOW.

In addition, several good Internet-based medical reference and research tools are available, both free and for a fee (see Appendix 5-C for a partial list). If you are from a legal clinic, you can access the Clinic Resource Office's website with its extensive list of links to these medical research sites. Representatives based outside the legal clinic system may want to contact their local legal clinic for assistance in accessing this information.

13.2.2 Tribunal Medical Discussion Papers

The Tribunal occasionally identifies medical issues for further investigation, and commissions recognized medical specialists in the field to provide general information in lay terms. These specialists are asked to present a balanced view of the current medical knowledge on the topic. The resulting medical discussion papers are not peer-reviewed. The Tribunal has accumulated more than 30 such medical discussion papers on a variety of topics, for example, Asthma and the Workplace, Industrial Dust Exposure and Chronic Obstructive Airways Disease, and Osteoarthritis. They are gradually being posted on the WSIAT website as they are updated and translated into French or English. Copies of papers not yet posted can be ordered from the WSIAT library. When a relevant paper exists, it is usually included in the Tribunal's case record in appeal.

Medical discussion papers come with the caution that they do not necessarily represent the views of the Tribunal or any particular vice-chair or panel. Nevertheless, Tribunal decisions show that significant weight is often placed on the medical opinions set out in these papers, as is the case with medical reports prepared by one of the Tribunal's independent medical assessors. When conflicting

medical evidence arises, most decisions treat a detailed Tribunal medical discussion paper on point as the better and more reliable medical evidence.

In Decision 378/01R (20 November 2001), the injured worker requested a reconsideration on the ground that the vice-chair erred in placing too much weight on the Tribunal's medical discussion paper. The paper in question does not accept that a limp from an injured knee would cause damage in the knee of the uninjured leg. A different vice-chair denied the reconsideration request on the ground that it was reasonable to place significant weight on the paper. The authors were recognized experts and they cited their research. The worker did not present any alternative studies, and the supporting medical opinion only suggested a possible medical connection, which was not considered strong enough to outweigh the discussion paper.

If a Tribunal medical discussion paper undermines your theory of the case, consider searching the medical literature for alternative views and/or seeking an additional medical report that acknowledges the discussion paper but maintains support for your argument.

NOTES

1. Decision 915 (1987), 7 WCATR 1 at 118.
2. Operational Policy Manual, Document 17-01-03.
3. SO 1991, c.18.
4. RSO 1990, c.H-19.
5. Available on the Canadian Medical Association's website at <www.cma.ca/index.cfm/ci_id/2419/0_jd/1.htm>
6. *Tran v. Drs. Elgie, Kaegi and MacFarlane*, unpublished decision of the Health Disciplines Board Complaints Committee, August 1990.
7. RSO 1990, c.H-4.
8. Posted on the Board's website at: <[www.wsib.on.ca/wsib/wsibsite.nsf/LookupFiles/AdjAdviceWeigh_Medical_Evidence/\\$File/WOME.pdf](http://www.wsib.on.ca/wsib/wsibsite.nsf/LookupFiles/AdjAdviceWeigh_Medical_Evidence/$File/WOME.pdf)>.
9. (1986), 3 WCATR 22 at 26.
10. (1986), 1 WCATR 190 at 193.
11. (28 December 2000).
12. *Supra*, note 9, p.27.
13. (1986), 1 WCATR 142 at 152.
14. *Supra*, note 10.
15. Decision 743/00R (25 June 2002).
16. Decision 945/94I (31 January 1995).
17. *Supra*, note 15.
18. (2003), 66 WSIATR 96.
19. [1992] 2 SCR 138.
20. SO 2004, c.3, Schedule A.
21. The College of Physicians and Surgeons of Ontario, Policy #11-00, May/June 2001.
22. See O.Reg. 114/94, s.19 as amended (Regulation under *Medicine Act, 1991*).
23. The Law Society of Upper Canada, adopted by Convocation on June 22, 2000.
24. Law Society of Upper Canada Gazette, Vol. XX, No.3, (September/December 1986).

25. See also the College of Physicians and Surgeons of Ontario's policy on "Third Party Reports", Policy #8-02, March/April 2003.
26. Decision 2747/00 (18 October 2001); Decision 72 (1986), 2 WCATR 28; and Decision 280 (1987), 6 WCATR 27.
27. Decision 250 (31 December 1986).
28. See Decision 915, *supra*, note 1, pp.251-252.
29. *Supra*, note 3.
30. SO 1991, c.30.
31. *Supra*, note 3, Schedule 2.

Chapter 5: Appendices

- 5A-1 to 2 Medical reference books
- 5B-1 to 2 Specialized health clinics
- 5C-1 Online medical resources

Medical Reference Books

The Minimal Office Library

The following types of books are recommended as a basic medical library for representatives undertaking workers' compensation cases. The texts named here are by no means the only good ones. We encourage you to "test drive" books before buying by looking over a book and trying it out on a couple of difficult files. Virtually all publishers will send texts by mail and allow you a trial period to decide whether to keep the book.

1. An illustrated medical dictionary, such as:
Dorland's Illustrated Medical Dictionary, 30th edition (Philadelphia, London, Toronto: W.B. Saunders Company, 2003).
2. A basic medical-legal text, such as:
Personal Injury: A Medico-Legal Guide to the Spine and Limbs by Darrell J. Ogilvie-Harris and Geoffrey J. Lloyd (Toronto: Canada Law Book, 1999).
3. A basic occupational medicine text, such as:
Occupational Medicine by Carl Zenz et al (Chicago, London, Boca Raton: Mosby Year Book, 1994); or
Occupational Health, Recognizing and Preventing Work Related Disease by Barry S. Levy and David H. Wegmen, 4th edition (Boston: Lippincott, Williams and Wilkins, 2000).
4. A basic drug reference book, such as:
Compendium of Pharmaceuticals and Specialties (Ottawa: Canadian Pharmaceutical Association, published annually).

The Good Office Library

A number of specialized books are frequently referred to in the course of doing a high volume of workers' compensation casework. They include the following:

1. *DSM-IV: Diagnostic and Statistical Manual of Mental Disorders*, 4th edition (Washington, D.C.: American Psychiatric Association, 1994).
This manual sets out the American Psychiatric Association's diagnostic system, commonly used by psychologists, psychiatrists, and the WSIB.
2. *Canadian Medical Directory* (Toronto: HCN Publications Company, published annually).
This listing of all physicians in Canada includes each physician's office address, university, and year of graduation, other degrees, specialist certification, and appointments to government agencies. Useful in finding doctors and assessing credentials, it also contains a list, by town, of all medical schools, physicians, and hospitals.

3. *Guides to the Evaluation of Permanent Impairment*, 3rd edition, revised (Chicago: American Medical Association, 1990).
The AMA manual used to rate disabilities as a percentage of impairment of the whole person. The WSIB uses it to rate NEL awards (see Chapter 16: Non-Economic Loss, Section 3.3.1 for details on ordering the *Guides*).
4. *Understanding Human Anatomy and Physiology* by E. P. Solomon and G. Phillips (Philadelphia, London, Toronto: W.B. Saunders Company, 1987).
A readable text intended for college level students. Some anatomy texts used in medical schools are difficult to use and understand.
5. *Harrison's Principles of Internal Medicine*, 16th edition (New York, Toronto: McGraw-Hill Inc., 2004).
A useful medical school textbook.
6. *Attorney's Dictionary of Medicine* (New York: Matthew Bender & Company Inc., 1997).
A large medical-legal reference dictionary.
7. *Attorney's Textbook of Medicine* (New York: Matthew Bender & Company Inc., 1997).
An extensive and expensive multi-volume compilation of rulings by courts and tribunals in the United States on personal injury matters. Although of little precedential value, it can sometimes be a source of confirmation that your medical-legal theory has been accepted before.
8. *Neuropsychological Toxicology — Identification and Assessment of Human Neurotoxic Syndromes* by David E. Hartman, 2nd edition (New York: Springer, 1995).
A standard reference text for the medical profession.

Specialized Health Clinics

1. Lakeshore Area Multiservice Program (LAMP) Community Health Centre

Occupational Health Program

185 Fifth Street

Etobicoke, Ontario

M8V 2Z5

Tel: 416-252-6471

Fax: 416-252-4474

TTY: 416-252-1322

Website: <www.lampchc.org/Programs-Services/occupationalhealth.php>

Funded by the Ministry of Health, LAMP will assist workers from all over Ontario, although they generally see workers who work or live in the west Toronto area. LAMP has only a few referral sources in the occupational health field for those who are unable to travel to LAMP or who live outside the area. As an alternative, LAMP will review the existing file and offer an opinion or recommendation based on the material provided.

LAMP has physicians on staff who specialize in occupational medicine as well as a co-ordinator with a background in health and safety. They deal with all occupational illnesses and injuries.

LAMP provides the following services:

- Medical-legal assessments and reports.
A small fee may be charged if a worker's representative has funds available without having to charge the worker. Otherwise, the fee will be waived.
- Literature searches and research.
LAMP will search online medical databases. They can access an Ottawa database of toxic substances and obtain information on various exposures. They also have a research library.
- Testing of exposure levels.
LAMP may provide some base level air testing to determine exposure levels. Although their equipment is limited, testing may indicate a problem, in which case LAMP would recommend an independent assessment. LAMP will examine results of previous tests (for example, Ministry of Labour reports) or conduct a walk-through of the site and offer comments or recommendations.
- Information and advice.
LAMP offers information on Workplace Hazardous Materials Information Systems (WHMIS), Joint Health and Safety Committees (JHSC), the *Occupational Health and Safety Act*, and counselling, rehabilitation, and other services.

2. **Occupational Health Clinics for Ontario Workers (OHCOW)**

Provincial Office: 15 Gervais Drive, Suite 601
Toronto, Ontario
M3C 1Y8
Toll free: 1-877-817-0336
Website: <www.ohcow.on.ca>

Clinics are located in Hamilton, London, Sarnia-Lambton, Sudbury, Toronto, and Windsor.

OHCOW clinics are sponsored by the Ontario Federation of Labour with a grant from the Ontario Ministry of Labour. They will perform medical assessments and provide medical-legal reports. They will conduct medical research and provide information on specific chemical hazards.

In addition to doctors trained in occupational medicine, clinic staff includes industrial hygienists who will carry out workplace assessments as appropriate. The occupational health co-ordinator works with Joint Health and Safety Committees to correct problems in the workplace.

3. **St. Michael's Hospital**

Occupational Health Clinic
30 Bond Street
4th Floor, Shuter Wing
Toronto, Ontario
M5B 1W8
Tel: 416-864-5074
Fax: 416-864-5421

This clinic has specialists in dermatology, respiratory diseases, hearing loss, repetitive strain, and white finger disease. Their doctors will examine an injured worker, and will prepare a medical-legal report for a fee. Sometimes they will arrange for workplace testing.

4. **McMaster University Program in Occupational Health and Environmental Medicine**

Occupational Health Clinic
McMaster University Medical Centre
1200 Main Street West, Area 2F
Hamilton, Ontario
L8S 4J9
Tel: 905-525-9140, extension 22387
Website: <www.fhs.mcmaster.ca/pohem>

This clinic provides a broad range of services related to the prevention, assessment, recognition, evaluation, and research of occupational health hazards and work-related injury and disease.

Online Medical Resources

Dictionaries:

E-Medicine	<www.emedicine.com>
Aetna Intellihealth	<www.intelihealth.com>
MedicineNet	<www.medicinenet.com>

Reference:

Hardin.MD, University of Iowa	<www.lib.uiowa.edu/hardin/md>
Harvard University Medical School	<www.med.harvard.edu >
Internet Mental Health	<www.mentalhealth.com>
Merck Source	<www.mercksource.com>
Duke University, School of Medicine	<medschool.duke.edu>
National Library of Medicine (with links to PubMed and MedlinePlus)	<www.nlm.nih.gov>
WebMD	<www.webmd.com>

Other:

Agency for Toxic Substances & Disease Registry	<www.atsdr.cdc.gov>
Canadian Centre for Occupational Health and Safety	<www.ccohs.ca>
Canadian Neurotoxicity Information Network	<www3.sympatico.ca/cnin>
The International Association for the Study of Pain	<www.iasp-pain.org>
National Institute for Occupational Health and Safety ...	<www.cdc.gov/niosh>
Ontario Health Clinics for Ontario Workers	<www.ohcow.on.ca>
Ontario Workplace Tribunals Library	<www.owtlibrary.on.ca>
Workplace Safety and Insurance Board	<www.wsib.on.ca>
Workplace Safety and Insurance Tribunal	<www.wsiat.on.ca>