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Canadian Environmental Law Association
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RECOGNITION OF OCCUPATIONAL DISEASES

A Brief to Professor Paul C. Weiler

from

THE CANADIAN ENVIRONMENTAL LAW ASSOCIATION

Presented by Michael Izumi Nash
Member, CELA Advisory Board of Directors

March 31st, 1981

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INTRODUCTION

The Canadian Environmental Law Association (CELA) is a national public interest group organized to promote the development of effective legal regimes for the improvement of the environment. Its membership of approximately 750 is made up of lawyers, law students and environmentalists of various professions. Many of the lawyer and law student members have appeared before the Workmen's Compensation Board and several are experienced practitioners in that forum. The Association is financed by donations from foundations, corporations, individuals and governments and by its membership and subscription charges.

When CELA was founded in 1970 the main focus of activity was the protection of the natural environment from pollution. Increasing experience in the law reform process, litigation, research and writing led the Association to become aware that pollution was not the only threat to the environment, and the environment was not just the out-of-doors. Since 1976 the Association has formally recognized as part of its mandate the need to relate its traditional concerns to the work enviornment: environmental assessment, public participation, access to

information and effective remedies.

Though there are competing theories about occupational accident causation, there is concensus that the work environment is the major factor in the causation of occupational disease. Further, most observers now agree that the recognition of occupational diseases by the Workman's Compensation Board falls far short of correlating with the true incidence of occupational disease. That this situation is unfair to the victim hardly needs elaboration. It is also probable that the under-recognition of occupational disease results in under-investment in its prevention.

Our Association is grateful for the opportunity to comment on a review of workers' compensation. We trust that a properly structured system of compensating the victims of occupational disease will result in justice for those afflicted and a better chance of preserving the health of the remainder. CELA hopes that its experience and perspective can contribute to the proper structuring of that system.

In our view, the obstacles to achieving a proper correspondence between recognition of occupational disease claims and the actual incidence of occupational disease can be grouped under four major headings:

I The decision making framework

II Statutory barriers

III The state of medical knowledge

IV The state of the claimant's exposure and health records

In this report we will look briefly at each of these areas in

turn to identify the nature of the problem and pose a suggested solution to overcome it.

In doing so, we have made certain assumptions. The first is that the recommendations which you have made in your report "Reshaping Workers' Compensation for Ontario" (November, 1980) will already be the law into which our suggestions for change must fit. The second is that in referring to "occupational disease" it is understood that all diseases that are or could be recognized as compensable are covered whether or not they fit the present definition of "industrial disease" found in The Workmen's Compensation Act, R.S.O. 1970, c. 505, s. 1(1)(1). The final assumption is that Ontario will continue for the foreseeable future to maintain a workers' compensation system discrete from other forms of accident and disease compensation.

Our brief is also subject to certain limitations. The most important limitation is that we are expressing our views only as observers and practitioners and not as researchers. We have not had the opportunity that other commentators have had to examine unpublished Workmen's Compensation Board statistics or to conduct surveys or polls of our own. Nor have we been able to perform economic analyses which could project the relative costs and benefits of our proposals. We can only say that in framing our suggestions we have tried to keep economic considerations in mind.

I The Decision Making Framwork

(a) Definitions

1. "Accident" and "Industrial Disease"

Ontario's Workmen's Compensation Act defines an "accident" to include:

(i) a wilful and intentional act, not being the act of the employee;

(ii) a chance event occasioned by a physical or natural cause; and

(iii) disablement arising out of and in the course of employment. (S. 1(1)(a)).

The definition of industrial disease has two parts: an industrial disease may be one listed in Schedule 3, or it may be any "disease peculiar to or characteristic of a particular industrial process, trade or occupation" (s. 1(1)(1)). The Schedule lists a number of diseases across from occupations or processes in which the disease can be contracted. If the claimant presents a case involving a listed disease while having worked in the appropriate listed occupation or process, then it is rebuttably presumed that the disease was "due to the nature of that employment" (s. 118(8)). If the disease is not listed in Schedule 3, the employee must show that the disease arose out of and in the course of employment, just as he would for an accident.[1]

In strict legal terms there appears to be an unnecessary evidentiary hurdle in the second part of the definition of industrial disease. Any disabling disease which arises out of

and in the course of employment is an "accident" within the meaning of s. 1(1)(a)(iii); having to prove that the disease is characteristic of a particular trade is legally superfluous.

Just because the second part of the definition of industrial disease is redundant does not mean that in practice its impact is neutral. In a claimant's favour, if a worker can show that a disease is characteristic of his trade, there is an unspoken presumption that it actually arose out of his employment. Unfortunately, however, there is also a converse unspoken presumption: if the disease is not proven to be characteristic of the trade, then it will generally be assumed that it cannot have arisen out of the claimant's employment.

The most frequent example of this unarticulated reasoning can be found in the numerous cases of degenerative disc disease (DDD). Because of the paucity of Canadian epidemiological studies on the subject, claimants are not able to show that DDD is characteristic of any particular trade. Workers with DDD who do assert claims that their back conditions are due to employment find that even with supporting medical opinions their claims are routinely denied. The stated reason in each case is simply that the disability is due to DDD. The unstated reasoning appears to be:

(i) DDD is not characteristic of any trade;

(ii) a disease not characteristic of any trade cannot be due to employment;

(iii) this particular claimant suffers from DDD;

(iv) therefore this particular case of DDD cannot be

due to the claimant's employment.

Yet, the fact is that in any individual case, DDD may have developed due to the movements or stresses demanded in the given job.[2]

Since the definition of industrial disease focuses inquiry on the peculiarity of the disease to a particular trade, the more relevant inquiry concerning causation in the individual case is often obscured. The net result of the second part of the definition of industrial disease then is to inhibit recognition of disease cases, even though that was surely not the intention of the legislators.

2. "Personal Injury" and "Disability"

Compensation is payable when there has been "personal injury" by accident or industrial disease arising out of and in the course of employment (ss. 3(1), 118(1)). In the sections of the Act which set out the scales of compensation, the Act makes compensation contingent on "disability" resulting from the "injury" (ss. 41(1), 42(1)). Nowhere are any of these terms defined.

Definition of these terms is especially important now that the risks of employment are appreciated to run beyond the traditional gamut of injuries. It is not sufficient to rely on a commonsense or intuitive standard in recognizing compensable injuries. While there may be no difficulty in an obvious case of trauma, back strain, dermatitis or hearing loss, there may well be a psychological or policy barrier to recognizing some of the more recently discovered forms of occupational hazard:

(i) reduced sperm count;

(ii) genetic mutation, even where a child is not born;

(iii) loss of libido;

(iv) chronic headaches;

(v) sensory impairment (smell or taste).

Any system of workers' compensation which is alive to these and a host of other risks being encountered in today's work world must be able to define the outer limits of what is covered.

3. A New Definition

In making suggestions for a new definitional approach we accept your proposed scheme of compensation for income maintenance and awards for permanent disability, a scheme similar to that now operational in Saskatchewan[3] and recommended for New Brunswick.[4] Indeed, we endorse Saskatchewan's use of the word "injury" as the triggering concept for payment of compensation. Unlike Saskatchewan, we would abandon the attempt to preserve the wording of Sir William Meredith and say simply that an injury is:

> A disturbance of or an interference with the structure and functioning of the body or mind.

The Saskatchewan definition is probably completely serviceable, but it is clumsy. It defines injury to mean:

(i) the results of a wilful and intentional act, not being the act of the worker;

(ii) the results of a chance event occasioned by a physical or natural cause; and

(iii) any disablement;

arising out of and in the course of employment; SS. 1979, c.w.-17, s. 2(k).

One cannot but note that the definition would make wage loss due to a lockout or layoff compensable under s. 68(1) of the Saskatchewan Workers' Compensation Act. Both lockouts and layoffs are wilful and intentional acts arising out of and in the course of employment. Further, the Saskatchewan definition perpetuates an anomoly from the Meredith-based statutes. By another section, no compensation is payable where the injury is due to "serious and wilful misconduct" unless the injury is severe or fatal. But strictly speaking, no injury whatever which resulted from the workers' own act would be compensable if the Board stuck to the definition of "injury" in s. 2(k)(i). If we intend to compensate for all injuries except those caused by serious and wilful misconduct, we might as well leave the worker's intention out of the definition and frame the exception in a separate section.

Our definition avoids the historic anomolies of the Meredith formulation and moves compensation closer to its goal of recognizing all proper cases of occupational injury, especially industrial disease. Specifically:

(i) there is no superfluous requirement that a disease be peculiar to a trade;

(ii) there is no doubt that any of the newly discovered risks mentioned earlier could be covered.

The definition by itself would not justify a compensation award for a permanent impairment under the scheme which you have proposed unless the specific risks were rated in the Schedule to

be developed by the Board. In that connection we would suggest that your final report make clear that the Board's mandate in drawing the new rating Schedule should include the kind of impairments which occupational medicine is now revealing. In particular, we feel that genetic mutation should be compensated whether a child is born or not. If out of fear based on occupationally caused genetic mutation a man or a woman avoids having a child, that certainly is an interference with the functioning of the body.

The definition does open a question which as far as we are aware, has not been widely treated in the compensation literature. That question is: to what extent do we want to compensate for chronic conditions which do not result in either present wage loss nor permanent disability? Our definition could include those conditions. We see in the stories of employees working at video display terminals (VDTs), for example, the possibility that headaches or eye strain may be present during part or all of every working day, but cease at the weekend, retirement or job change. The same concern might apply to people who develop psychiatric or psychological disorders under the stress experienced at work, but who could be expected to improve once the necessary alterations were made in the job design.

If our suggested definitions of injury were simply plugged into either Saskatchewan's or Ontario's present compensation statute it is clear from the sections setting out the payment scale that nothing would be payable for chronic conditions. If a policy decision is taken now to continue to exclude chronic

conditions then our definition of injury may certainly be used anyway. But we do raise for your consideration whether a modern system of compensation might not properly address the phenomenon of chronic conditions caused by or at the workplace. Our Association has not as yet reached any definite policy conclusion on compensation for chronic conditions. But we do feel that they are currently an unrecognized cost of production now being borne entirely by the employees. We doubt that these conditions were even contemplated in the historic compromise which led to the founding of workers' compensation. Administratively, it may be too difficult or costly to set up a scheme to compensate for these conditions, but if so, then at least that unrecognized burden would have to be borne in mind when assessing the overall fairness of the final scheme.

(b) Proof, Onus and Presumptions

1. Onus of Proof

We have already noted that where a claim does not fall within Schedule 3, the claimant has the onus of proving that he has an industrial disease arising out of and in the course of employment. As a articulated policy on the onus of proof, Ontario's position differs from that of some other WCBs, such as British Columbia.[5] In principle, British Columbia's approach is preferable.

The attraction of removing the onus of proof from the employee is to make the inquiry model of decision making more internally consistent. It simply makes sense in an inquiry system like workers' compensation to recognize that the inquirer's role

is to determine the truth, and not to wait and see whether each individual claimant can discharge the onus of proving a case.

2. Proving Causation

Much more fundamental than the question of onus of proof is the question of the necessity of proving that a disease, in fact, arose out of and in the course of employment. The evidence to prove that point may objectively not be present, no matter who has the onus of adducing it or of proving the case. That the evidence may be lacking is not the same as the proposition that the claim does not represent a legitimate occupational disease: the epididemiological, clinical or research literature may not be sufficiently developed; the toxic properties of certain substances may not yet be suspected or proven; the individual's records may be spotty, inaccurate or incomplete.

As we noted earlier, the concensus is that recognized occupational diseases are probably only a fraction of true occupational diseases. Moreover, comparative statistics show that relatively similar jurisdictions have a tremendous variation in the rate in which they recognize occupational diseases. Ontario recognizes almost 5 times the number of industrial disease cases as the United States, but only 40% as many as Sweden, after allowing for the differences in the size of the workforce in these jurisdictions.[6]

One can only conclude that institutional factors must largely account for the wide disparity between recognized and unrecognized cases of occupational disease and especially the wide disparity in recognition rates among jurisdictions. In our

view, the single most important factor among institutional obstacles to occupational disease recognition is the requirement of proof of causation.

The Ontario Board knows that this is the case and has commendably embarked on a pace-setting programme of developing guidelines for the recognition of industrial diseases. In recent years, the Board has been able to add two or three new guidelines annually. This comparatively aggressive stance is probably the chief factor putting Ontario in the lead on the continent in the recognition of industrial diseases.

An illustration of the effectiveness of the guidelines is the case of vibration-induced white finger disease:

> In January of 1978, the Board approved the newly developed guidelines for adjudicating claims by miners suffering from vibration-induced white finger disease. The disease occurs after the repeated use of hand-held vibrating tools and the jack-leg drills employed by miners. The vibration causes the walls of blood vessels in the fingers to contract, producing numbness and discomfort. Before the guidelines were adopted, only seven permanent disability awards had been made in 204 cases of white finger disease (although many other cases were granted lesser forms of compensation). With the guidelines in place, the total number of cases granted permanent disability pensions rose to 86.[7]

Sadly, the effectiveness of the guideline also points out the inequity which precedes it.

Our present regime of requiring proof of causation alleviated in specific instances by presumptions arising out of guidelines, cannot but fail to compensate all deserving cases. The whole field of occupational disease is expanding far more rapidly than a guideline policy can ever cover.

Our Association recommends that a reformed Workers'

Compensation Act statute provide a new framework for dealing with recognition of occupational diseases. In this framework, a series of legislative presumptions would help provide the Board with a way to overcome the deficiencies of the present scheme of recognition:

(i) Where there is some evidence that an injury has or could have arisen out of and in the course of employment, the injury shall be presumed to have arisen out of and in the course of employment unless there is substantial evidence to the contrary;

(ii) "Some evidence" does not include the mere fact of a claim having been made, but does include:

- any epidemiological literature or data identifying a statistically significant relationship between a particular injury and a particular type of occupation or occupational process;
- any medical opinion supporting a possible causal relationship between the injury and the occupation or occupational process;
- any anecdotal evidence supporting a possible causal relationship between the injury and the occupation or occupational process.

(iii) Where any injury meets the criteria of a guideline developed by the Board or falls within the provisions of Schedule 3, the injury shall be presumed to have arisen out of and in the course of employment in the absence of

proof to the contrary;

(iv) Where an injury is dealt with in a guideline or in a Schedule, but does not meet the criteria of that guideline or Schedule, no inference or presumption shall be drawn from that fact.

We had considered advancing a bolder presumption, namely that all injuries shall be presumed to have arisen out of and in the course of employment in the absence of substantial evidence to the contrary.[8] We rejected this presumption with some reluctance out of a fear that it might be abused. We felt that the "some evidence" requirement should strike an acceptable balance to avoid abuse and yet get all possible legitimate claims before the Board.

In advancing this suggestion of a "some evidence" presumption we were strongly influenced by research results reported in the United States.[9] This material indicates that in certain occupations where one might reasonably expect to find elevated levels of occupational diseases, there was a striking correspondence with the number of people reporting those occupational diseases. The conclusion was tentatively drawn that the individual's judgment provides a reasonable indicator of job-relatedness. We felt on that basis that if a claim could be supplemented with any evidence at all, then the claim should be allowed unless substantial contrary evidence could be found.

3. Multiple Causation

Workers' compensation has always demanded a causal link between

the claimed injury and the employment. With industrial diseases especially, the causal link can be very tenuous. As research progresses the multiplicity of possible contributing factors becomes more evident and the adjudicative process more confusing. As the cost of compensation escalates there are growing demands that non-occupational causative factors should be considered, especially where these are voluntarily assumed.

The Board's present policy on pre-existing conditions is to take them into account only when calculating the permanent disability pension. From the total assessed degree of disability the Board deducts the percentage disability which was measurably present prior to the injury. The policy is one that we can support, although we would prefer to see it given legislative status.

When the non-occupational causative factor is not a pre-existing condition, but rather a susceptibility or increased risk due to the presence of a non-occupational factor, the Board's policy appears to be to compensate for the entire resulting disability. Again, we find nothing objectionable in that policy and we believe it ought to be maintained even in the face of pressure to change it.

The real problems arise when the injury could be due to any number of factors, only one or some of which are occupational. The Board then must decide to which factors causation will be attributed. Our suggested approach to causation outlined above will make that task somewhat easier and, we believe, fairer. Where there is some evidence that a disease is or could be occupational the Board will have to produce substantial evidence

to the contrary in order to deny the claim. We believe this will approximate the balance of actual probabilities in the majority of cases; it shifts the evidentiary burden away from the person least likely to be able to discharge it; and it can only have a more profound impact on the use of potentially toxic substances than the present system does.

More problematic are the cases where the factors pre-disposing to injury are occupational but the final causative factor is non-occupational. It is not hard to imagine a case where a claimant could show that a car accident was brought about by a delayed reaction to a toxic substance at the workplace which caused him to lose attention or control. A case has already been advanced in British Columbia involving an allegation that the workplace predisposed the claimant to alcoholism.[10]

Knowing how to handle these cases depends on knowing what the scheme is trying to accomplish. If we are really trying to compensate people for their injuries causally related to their work, then it is not fair to attempt to disentitle people because of the character or timing of other causative factors. The attempt could be made to exclude cases where the final causative factor was voluntary (like alcoholism), or where the non-occupational pre-disposing factor was voluntary (like smoking), but any such attempts would have to be seen as arbitrary and not consistent with the purpose of compensation.

After all, the historic compromise made in the early part of this century was that workers were giving up the right to sue for pain and suffering in exchange for being compensated for wage loss

and permanent disabilities on a no-fault basis. Denying recognition now because some causative factors are voluntary is essentially a return to a fault system involving contributory negligence. If we are going to unravel the compact at that end, the corollary is that it must be unravelled at the other and permit compensation for pain and suffering where there is fault.

There is a terrible irony in the view which is sometimes expressed that voluntary causative factors should reduce or eliminate compensation for occupational diseases. The theory behind the view is that employers have no control over the habits of the employees. Yet, it is only in interaction with the workplace environment that a compensable injury is produced, and the employer does control the environment. And probably strict control of the environment can reduce the incidence of occupational disease even more than it can the incidence of accidents.

As an Association concerned especially about the quality of the workplace environment, we see any move toward disentitlement on the basis of voluntary factors to be a retrograde development. While there is no solid data to back the theory that increased assessments promote investment in occupational health and safety, it is reasonable to assume that businessmen will make investment decisions in favour of occupational health and safety when the cost of not doing so becomes greater. That being the case, we say that the cost of having a workplace design which promotes alcoholism or increases risks to smokers should be brought home to employers no less than the cost of an occupational environment which promotes back strain.

(c) Evidence

In industrial disease cases which fall outside the scope of Schedule 3, and which are not favoured by one of the guidelines that the Board has developed,[11] the two major issues are the peculiarity of the disease to the occupation, and the precise causation in the particular case. The first of these issues is statistical or epidemiological; the second is medical. A worker trying to accumulate evidence to meet these two issues has a number of obstacles to face.

1. Epidemiological Evidence

On the statistical or epidemiological side, the worker generally will have little opportunity or talent for searching the available literature, and even less for doing the research himself. Many representatives are in no better position. Instead, the employee can usually only put forward his claim and see if the Board will allow it, whether in the first instance or on appeal. The Board tries to reassure claimants by saying it "will then obtain the necessary information required to determine whether the claim is acceptable".[12]

The claimant is really in an impossible situation. Only an exceptional worker or representative has the resources or faculties to marshall the epidemiological information to prove the required peculiarity of the disease to the occupation.[13] Second, even if he does the research, the answers may be inconclusive, perhaps due to the lack of respectable studies on the particular disease or occupation.

Most importantly, if he relies on the Board to obtain the necessary information he does not know how far the Board looked, what weight it attached to certain information as opposed to other conflicting information, precisely what literature was considered, or whether in the end the case was decided simply because the necessary research has not been done. At no stage of the Board proceedings is any detailed information given to the claimant on these points.

The problem of how to address epidemiological evidence fairly will not disappear even if our earlier suggestions are implemented. A claimant under our scheme would still need to have some evidence in support of his claim in order to benefit from the presumption in favour of recognition. If he has not submitted any such evidence, it will be up to the Board to determine whether it exists. If the Board makes its decision in the same inscrutable fashion it has used in the past, there will be little progress.

We would suggest the following procedure for dealing with epidemiological evidence. A claim reaches the Board involving a disease which the Board doctors doubt could be related to the employment because of the literature or lack of it on the subject. The Board writes back to the employee stating the exact reasons for doubt and offering to produce the relevant bibliographic references relied upon and not relied upon, and also offering to produce any of the articles available. If nothing else happens the Board could then deny the claim. If the employee asks the Board to produce the bibliography or articles the Board could wait for a further response before making a decision, which might

also include a hearing. When the decision is made, any articles relied upon would be cited and the reasons for accepting them stated.

This kind of open procedure would fit nicely into the decision-making model suggested both by Professor Ison[14] and by you.[15] It has the advantage of giving the claimant a visible opportunity to be sure that the Board's conclusion is indeed justified by the evidence. If the decision is not justified, the claimant at least has the starting point for intelligent preparation of an appeal. Moreover, this reform would probably have the effect of ensuring that the Board was actually operating with all the latest and most reliable epidemiological information. It might even have the effect of spurring more research as the lacunae become increasingly evident.

2. Medical Evidence

On the question of causation in an individual case, a typical industrial disease case involves the opinions of several doctors. The Board's task is to evaluate the opinions, select the most probable cause and decide accordingly. Almost without fail, the Board approves the opinion of its own medical staff and implicitly rejects the opinions of other medical or lay witnesses where there is a conflict with the Board doctor.

Our Association does not suggest that Board doctors should be eliminated, or that their opinions should not be preferred, but we believe very strongly that the opinions of the Board doctors have to be evaluated by reasonable, articulated criteria. At the moment, this is not done. The Board will merely state that it has

referred the case to the consultant, it has considered the evidence, and it is denying the claim.

We believe the Board's practice in receiving and preferring the opinions of its own doctors may be a major inhibiting factor in the recognition of occupational diseases. Our observation, which we find confirmed by academic writers[16] is that the Board personnel have or develop a certain perspective which affects their observations and conclusions. In particular, Board doctors tend to over-emphasize the role of non-occupational factors in the etiology of disease or disablement. There may not be anything conscious or sinister in this tendency. We suspect that it comes fairly naturally from the job. The Board doctors are never challenged on their opinions; in cases involving claims recognition they never meet or get to assess the claimant; they know there are financial limitations involved in the administration of workers' compensation; they are faced with a certain number of unfounded or even fraudulent claims; and they have contact with others under the same constraints.

Indeed, the Board doctors follow the same pattern of reaction to external and internal variables as do other doctors, or as do any of us:

> Different doctors perceive and respond to these tenuous, imprecise issues in different ways, influenced by their position, their relationship to the parties, their theories about medical treatment, and even their social philosophy regarding programs such a workers' compensation.[17]

That these variables influence medical opinions in the profession at large is now beyond dispute. They cannot but be a factor at the Workmen's Compensation Board.

As an evidentiary question, it is not the conservative tendency of Board doctors alone that inhibits recognition of occupational diseases. Perhaps more importantly, it is the virtually mechanical preference accorded to their opinions. In practice, the Board does not give itself sufficient credit for its own ability to make reasoned judgments on issues which have a medical component. We believe that the Board commissioners are or should be able to assess the relative weight to be attached to conflicting medical opinions in light of such factors as:

(i) the doctor's credentials and experience;

(ii) the doctor's opportunity to assess the claimant;

(iii) the history on which the doctor based his opinion;

(iv) the reasoning process employed by the doctor;

(v) the background provided by the scientific or medical literature.

If the Board were to embark on that kind of decision making, the quality of the Board's medical opinions could only increase. At present, an examination of any rejected claim file will show medical-legal reports from Board doctors at a maximum of three or four sentences, and typically only this curt notation: "Medically, I am in agreement to deny entitlement". At present, that opinion will take precedence over a detailed three-page report provided by any specialist the claimant might have had, and the Board will not say why.

We recommend a series of guidelines to the Board in handling evidence consisting of medical opinions which, if followed, would

overcome the problems discussed here:

(i) the Board shall give reasons for preferring one medical opinion over another;

(ii) the Board shall not prefer one medical opinion over another only on the ground that the opinion's author is or was a Board staff member or consultant;

(iii) if the Board has considered or proposes to consider any medical or scientific article, access to it shall be offered to the claimant, and it shall be referred to in the reasons for decision.

We take no position on whether these guidelines need to form part of the statute. We would be content if the Board adopted them as part of its official policy.

The Board typically makes a practice of referring medical questions to its staff or it consultants following an appeal. The resulting opinion is not usually communicated to the claimant but will typically be the determinative factor in the disposition of the appeal. The claimant is not told precisely what question or supporting materials are put to the staff or consultant and has no opportunity of framing the question or limiting the material. If the claimant wants to submit further evidence, he must arrange and pay for a new medical-legal report on his own.

This practice strikes us as grossly unfair and probably constitutes another impediment to the making of proper decisions on claims' recognition. In our view, when the Board desires further medical opinions it should:

(i) give the claimant an opportunity to participate

in the framing of the medical question and the listing of the supporting materials;

(ii) offer the claimant to have an opinion prepared by a specialist of the claimant's choice, on similar terms, at the Board's expense;

(iii) offer the claimant an opportunity to have the appeal hearing reconvened following exchange of the medical opinions to receive further evidence and argument arising out of those opinions.

(d) The Role of the Employer

Our impression is that more occupational disease cases are contested by employers than are accident cases, and that their opposition correlates with rejection rates. Certainly available statistics from the United States[18] supports this impression although we have not had access to comparable Canadian statistics. Our further impression is that employer opposition adds nothing of an evidentiary nature that could not be obtained by the Board summoning the employer as a witness. Instead, we suspect that the presence of the employer as an adverse party is itself an inhibiting factor in recognition cases.

If the nature of the Board record keeping permits verification of our impressions, or if other practitioners before the Board could be polled for their impressions, we would ask that you conduct the required research. We are afraid that opposed cases are handled unnecessarily harshly, thereby biasing the recognition rate downward.

If our impressions can be verified or corroborated, we believe that you would have ample justification for recommending that the employer not be a party to the proceedings. Instead, the employer would simply be one witness whom the Board may summon in exercise of its inquisitorial powers.

There is some precedent for taking this step, initially surprising though it may be. Within the compensation scheme itself we note that employees are not parties to matters involving employer assessments, even though the employees have a very important stake in the size of those assessments. Within the broader insurance context, we observe that all insurers are given the right to control legal proceedings arising out of a claimed loss without any necessary participation of the insured party.

Removing the employer as a party could also be justified on a more theoretical basis. Dealing as we are with an inquiry system, the Workman's Compensation Board is mandated to make its decision on the real merits of the case. It should not be concerned with the question of who won an adversarial conflict. In Canadian workers' compensation we abandoned long ago the idea that adversarial processes had anything useful to contribute, a discovery being made only now in the United States. Yet our proceedings in occupational disease cases are becoming increasingly adversarial, fostering bitterness and, we believe, retarding the process of making fair decisions on recognition.

What would be the practical effect of removing the employer as a party? The employer would only be entitled to be present at a hearing to the extent necessary to give his evidence; he would

have no right to question the claimant and no right to make submissions or argument. The Board would continue as it has traditionally done, making its own investigations, seeking its own opinions and generally conducting whatever inquiries it felt might be useful in adjudicating a case. It is our hope that the step might remove some of the acrimony from Workman's Compensation Board proceedings and permit more dispassionate decision making.

II Statutory Barriers

All of the present Canadian workers' compensation statutes, except Saskatchewan's, contain provisions against recognition of industrial diseases on the basis of time and residence. The effect of these restrictions can be offset by interprovincial agreements or proof that the claimed disease did, in fact, arise wholly within the province. In Ontario these restrictions are contained in section 118, subsections (8) and (10) to (13).

We strongly doubt whether any of these provisions have anything to do with the etiology of or disability caused by industrial diseases. Their rationale appears rather to be to exclude all cases that might have arisen out of employment in another province. Arguably, an employee has the right to make a claim in his former province. In fact, such a claimant might well find himself barred by time or residence restrictions in the former province, or unable to collect for that portion of his disability attributable to Ontario employment.

What is needed is a strong initiative by Ontario to have all

Canadian jurisdictions delegate to each other the responsibility for apportioning the financial cost of compensation according to the jurisdiction of origin. Each jurisdiction would pay the claims recognized by it, but apportion the appropriate percentage of the cost to the other responsible jurisdictions. Those jurisdictions would then reimburse the paying board.

In the absence of agreement, we suggest that Ontario follow the lead of Saskatchewan and unilaterally abolish its artificial barriers to recognition of industrial disease. We appreciate this will involve an indeterminate amount of unrecoverable costs, but our judgement is that the Ontario initiative and pressure could not long be ignored by the other provinces and the territories. In any event, some of the costs could be recovered by permitting the Board to make a subrogated claim in a worker's name in the foreign jurisdiction.

III The State of Medical Knowledge

In any jurisdiction, one of the chief obstacles to identifying occupational disease is the state of medical knowledge. Researchers and specialists often find that with any given disease they have insufficient knowledge of the cause, or cannot distinguish between occupational and non-occupational causes of disease. A reform of of workers' compensation can do little to advance research or reduce the level of uncertainty in these areas. The workers' compensation boards are not primiarly instruments of medical research; the most they can do is to collate and disseminate the statistical data available to them in a manner useful to researchers

in other institutions.[19]

On the other hand, the Workmen's Compensation Board is very well situated to encourage the wider dissemination of existing medical knowledge among doctors, employers and employees. As an institution it would be expected to have more information on occupational diseases at its disposal than any other institution in the province. Because it controls both payment to doctors and assessments from employers it has a ready-made instrument for encouraging the spread of information among those groups.

(a) Doctors and Patients

Among doctors, we find that there is no financial incentive to become knowledgeable in occupational medicine. There are no specialty programmes in the area in Canada and only a few diploma programmes. Both OHIP and the Workmen's Compensation Board only accord preferential billing rates to specialists and not diplomates. It is therefore not in a doctor's financial interest to take a diploma course in occupational medicine, or even for that matter, to attend a continuing medical education seminar in that topic, both of which cost the doctor money.

We submit that the structure of medical education and of billing privileges must be altered to allow financial rewards for the financial sacrifice of acquiring more information. The Board cannot of itself cause the establishment of specialty programmes in occupational medicine, but it can use its prestige to lobby for changes in that direction. Moreover, it can certainly be mandated to conduct continuing medical education seminars or

conferences in cooperation with the existing medical associations, academies and teaching hospitals. Most importantly, it can change its billing practices to remunerate more adequately those who take the trouble to participate in such programmes.

The design of a preferential payment scheme need not be complicated. Already, the various specialties require that doctors put in a certain number of hours at teaching functions in order to retain specialist standing. The Board or OHIP, if medical aid becomes an OHIP responsibility, could simply indicate new billing rates for occupational health diplomates or for other doctors who maintain their standing by accumulating a specified number of educational credits annually. Research findings indicate that participation in appropriately designed education functions yield impressive results in knowledge assimilated and put into practice.[20]

The Board could also mount a somewhat more aggressive medical education programme in the professional literature. At present, it contributes a one page monthly article "Interface" to the Ontario Medical Review. The article can only touch upon medical topics, and is frequently devoted to such necessary administrative information as practicing doctors need to know in dealing with the Board. We have no doubt that more could be done in the way of contributions to widely read medical journals by Board staff or consultants. We suggest that the presence of frequent occupational health articles in the popular medical journals cannot but have an impact on the level of physican awareness.[20]

The Board or OHIP might also want to amend their payment schedules to specifically recognize the value of occupational history-taking and education of patients in what they need to know about occupational medicine. The present schedules do not reward doctors for the extra time they might have to spend in order to develop the kind of occupational-medical chart necessary to permit educated diagnoses. Nor do they remunerate doctors for the additional time it might take to educate patients about preventive techniques they might employ, about signs and symptoms for which they must be alert, or about the mechanics of diseases they might be contracting or in danger of contracting. Instead, payments for consultations put the financial premium on spending the least time possible with the patient. Yet the value of that effort is clearly recognized as a way of properly serving the victims of occupational disease.[21]

(b) Employers

While there is some cogency to the argument that investment in safety is profitable, it is not so obvious that investment in occupational health is profitable. An employer may have to make very expensive changes to prevent what he may consider marginal or even speculative disabilities at some indeterminate future date. Further, an employer who shares his information on occupational hazards and occupational medicine with his workers may find greater levels of labour unrest, more workers' compensation claims, or more refusals to work in unsafe conditions. In short, the more he knows about occupational health, and the more

he shares with his employees, the more he is likely to have to spend without any tangible reward.

Our Association believes that it is time to understand that employers cannot be expected to put significant investment in occupational health without altering the financial balance a successful businessman has to consider. We propose that just as doctors should be able to maintain higher billing privileges with accreditation in occupational health programmes, so should employers be able to maintain reduced assessments with similar accreditation. The Board, in cooperation with the safety associations (IAPA, MAPA, etc.), already sponsors many educational functions on safety. We suggest that these functions be expanded to cover occupational health and that regular participation in them result in a proportionate decrease in assessments. This kind of preferential treatment is recognized as effective in the case of drivers and lawyers, and we see no reason why it would not be effective with employers if properly structured.

We appreciate the necessary corollary of adopting the preferential assessment scheme would be to increase the overall rates of assessment; if some paid less, others would pay more. In our view, this would be a welcome natural consequence because it might well draw more attention to the necessity of becoming informed.

IV The State of the Worker's Record

Occupational disease claims are often difficult to adjudicate simply because it is not possible to ascertain to what substances

and to what degree a worker has been exposed in his past or present employments. Further, claims may not even be presented because in the absence of decent records neither the doctor nor the worker are alive to the potential hazards to which the worker has been exposed.

Ontario's proposed Designated Substances Regulations,[22] if enacted and followed, should result in the compilation of excellent exposure records for the substances designated. Unfortunately, the scope of occupational diseases runs far ahead of the dangers posed by those six substances (asbestos, silica, lead, mercury, isocyanates and vinyl chloride). The need is to have an exposure record available for the worker and his doctor on any agent in the workplace which may cause occupational disease. The administrative problem is how to meet this need without prohibitive effort and cost.

The dimensions of the problem can be reduced somewhat by confining attention to a limited range of potentially harmful agents at one time. Our view is that at the moment the category of agents about which the least is known and from which the potential harmful effects are the most awesome are chemical agents. Among those agents, a division may be made between "new" agents and those which are not new, borrowing from the use made of that term in section 21 of The Occupational Health and Safety Act, S.O. 1978, c. 83.

(a) New Chemical Agents

Section 21 requires notice of new agents to be made to the Director. New agents are those not included in the Toxic

Substances Control Act Chemical Substances Inventory published under the U.S. Toxic Substances Control Act, P.L. 94-469. At present, notice of the new agent need not be given to the employees, nor does the Director have any authority to require notice to the employees.

A modest beginning to the creation of proper exposure records could be made by altering slightly the format of the s. 21 scheme. First, notice of the intended introduction of a chemical agent should also be made in duplicate to the potentially affected employees. Second, where the Director permits the introduction of a new agent whose harmlessness has not been conclusively proven, he should require that a second notice be provided in duplicate to every affected employee setting out the date that the agent will be introduced. An employee could keep one copy of each notice and give the other to his physician, so that charts could be kept respectively by each of them. The notices could be reproduced in bulk and in most cases would be neither lengthy nor costly.

Where joint health and safety committees were set up, and where the committees and employers were so minded, monitoring programes could be designed and personal exposure records generated, following the model of the Designated Substances Regulations. These personal exposure records would be the ideal supplements to the initial notices, creating a complete chart of exposure to new chemical agents.

(b) Carginogens

Among the agents which are not new within the meaning of s. 21 of The Occupational Health and Safety Act, there is a small group of known or suspected carcinogens as identified by the American Conference of Governmental Industrial Hygienists,[23] or by the Workmen's Compensation Board.[24] Some of these are dealt with in the proposed Designated Substances Regulations (asbestos, silica, some isocyanates, vinyl chloride), but many are not. A few may be deemed to be toxic substances and dealt with under s. 20 of The Occupational Health and Safety Act where one of the Director's requirements could be the creation of personal exposure records. Finally, some will be the subject of programmes designed by joint health and safety committees. But inevitably, many workers will have no protection from many carcinogens.

Our submission is that there must be at least adequate exposure records for all occupational carcinogens. We do not think that the development of these records can be left to the chance of being dealt with by the Director or the joint health and safety committees. In our view, the least that can be done is to have all known or suspected carcinogens intensively monitored and the results channelled into personal exposure records for the use of the worker and his doctor. The monitoring and record keeping requirements should be mandatory under The Occupational Health and Safety Act in respect of any agent identified as a known or suspected carcinogen by the Workmen's Compensation Board or the American Conference of Governmental Industrial Hygienists. We are aware that your mandate does not include The Occupational

Health and Safety Act as such, but we assume that you are free to make recommendations touching that statute where necessary to advance the interests of workers' compensation.

CONCLUSION

We agree that in the end, any system of compensation which depends on the cause of the injury and not its severity is bound to be unfair.[25] But we are convinced that if our modest proposals were accepted, the correlation between occupational disease and compensation would come far closer to what it ought to be than it does at the present time.

Moreover, the scheme of universal accident and sickness insurance which has been tried in part in New Zealand [26] and proposed for Manitoba [27] holds great attraction for us, as long as employers must still continue to pay for occupational injuires. Even though we have not examined the difficulties and concepts of a universal scheme in this brief, we nevertheless submit that the recognition issue examined here would still be relevant and have to be carried forward into such a scheme. While it is true that an award would not depend on recognition of an injury as occupational, nevertheless, under any system which has prevention as its secondary goal, the primary financial responsibility must still be sited where it has the greatest preventive potential: with the employer. To that extent, allocation of causes and fixing of assessments should continue to be important issues under any compensation scheme.

SUMMARY OF RECOMMENDATIONS

course of employment unless there is substantial evidence to the contrary;

(ii) "Some evidence" does not include the mere fact of a claim having been made, but does include:

- any epidemiological literature or data identifying a statistically significant relationship between a particular injury and a particular type of occupation or occupational process;

- any medical opinion supporting a possible causal relationship between the injury and the occupation or occupational process;

- any anecdotal evidence supporting a possible causal relationship between the injury and the occupation or occupational process;

(iii) Where any injury meets the criteria of a guideline developed by the Board or falls within the provisions of Schedule 3, the injury shall be presumed to have arisen out of and in the course of employment in the absence of proof to the contrary;

(iv) Where an injury is dealt with in a guideline or in a Schedule, but does not meet the criteria of that guideline or Schedule, no inference or presumption shall be drawn from that fact. 13

6. There should be no reduction of or disentitlement to compensation only because some or one of the causative factors in an injury was non-occupational, whether voluntary or not. The only exception would be the Board's present policy on pre-existing conditions. 14

7. Where the Board intends to deny a claim because of the absence of epidemiological evidence to support it,

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the Board shall produce the references, articles and reasons for making that decision. 19

8. The Board should adopt guidelines for the evaluation of medical opinions as follows:

(i) the Board shall give reasons for preferring one medical opinion over anonther;

(ii) the Board shall not prefer one medical opinion over another only on the ground that the opinion's author is or was a Board staff member or consultant;

(iii) if the Board has considered or proposes to consider any medical or scientific article, access to it shall be offered to the claimant, and it shall be referred to in the reasons for decision. 23

9. Where the Board seeks further medical evidence following an appeal, it should:

(i) give the claimant an opportunity to participate in the framing of the medical question and the listing of the supporting materials;

(ii) offer the claimant to have an opinion prepared by a specialist of the claimant's choice, on similar terms, at the Board's expense;

(iii) offer the claimant an opportunity to have the appeal hearing reconvened following exchange of the medical opinions to receive further evidence and argument arising out of those opinions. 23

10. The role of the employer as an adverse party should be evaluated; if found to be an unnecessary inhibitor to claims recognition the role as party should

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FOOTNOTES

1. Workmen's Compensation Board, Board Policies and Administrative Directives (Toronto: looseleaf), Directive 1 under s. 118(1), p. 178.

2. J. S. Lawrence, Rheumatism in Populations, (London: 1977) pp. 68-97, 466-493.

3. S.S. 1979, c.w.-17.1.

4. New Brunswick, Report of the Workers' Compensation Study Committee, (Fredericton: February, 1980).

5. (1980) 5 WCR 78.

6. U.S. Department of Labour, An Interim Report to Congress on Occupational Diseases, (Washington: June, 1980), p. 72.

7. Workmen's Compensation Board, Annual Report 1978, (Toronto: 1978), p. 14.

8. The Longshoremen's and Harbour Workers' Compensation Act, 44 U.S. Statutes 1424, s. 920 provides in part:
In any proceeding for the enforcement of a claim for compensation under this chapter it shall be presumed in the absence of substantial evidence to the contrary
(a) That the claim comes within the provisions of this chapter.

9. U.S. Department of Labour, op.cit., pp. 44-48.

10. "Canadian Occupational Health and Safety News", Vol. 4, No. 2, January 21, 1981, p. 2.

11. The criteria are published in WCB, Board Policies and Administrative Criteria, op.cit., Directives 14-19 under s. 118(1), Directive 1 under Schedule 3(5), Directives 1 and 2 under Schedule 3(6), Directives 1 to 6 under Schedule 3(8) and (12), pp. 185-198. They deal with toluene diisocyanate, vibration-induced white finger disease, laryngeal cancer in asbestos and nickel exposures, chronic obstructive lung disease in smelter workers, caisson disease, dermatitis venenata, silicosis, asbestosis and tuberculosis.

12. Workmen's Compensation Board, Occupational Diseases, (Toronto: no date), p. 3.

13. An example of such an exceptional worker is Gus Froebel. See Lloyd Tataryn, Dying For a Living, (1979), pp. 73-78.

14. Prof. T. G. Ison, Information Access and The Workmen's Compensation Board, Commission on Freedom of Information and Individual Privacy Research Publication 4, (Toronto: January, 1979), pp. 22-24.

15. Prof. Paul C. Weiler, Reshaping Workers' Compensation for Ontario, (November, 1980), pp. 94-97.

16. Prof. T. G. Ison, Accident Compensation, (London: 1980), p. 28; G. B. Reschenthaler, Occupational Health and Safety in Canada: The Economics and Three Case Studies, Institute for Research on Public Policy, (Montreal: 1979), p. 101. In a private conversation between Jack O'Brien, Executive officer of the Workers' Compensation Appeal Board of Nova Scotia and the author, March 20, 1981, Mr. O'Brien stated that the Appeal Board considers that both the family doctor and the WCB doctor have or may have special interests which affect their opinions. In practice the Appeal Board will prefer neither of their opinions but defer to the opinions of medical specialists in private practice who are consulted on an individual basis by the Appeal Board or the parties.

17. Weiler, op.cit., p. 118.

18. U.S. Department of Labour, op.cit., pp. 69-71.

19. Ison, Information Access and The Workers' Compensation Board, op.cit., pp. 174-182.

20. Dr. Lynn Curry and Dr. Wayne Putman, "Continuing medical eduction in Maritime Canada: the methods physicians use, would prefer and find most effective", Canadian Medical Association Journal, Vol. 124, No. 5, March, 1981, pp. 563-566.

21. The Hon. Bette Stephenson, "The New Medical Frontier: Collective Bargaining Over The Examining Table", Canadian Family Physician, Vol. 24, June, 1978, p. 528.

22. Ontario Gazette, August 16, 1980, pp. 3,338-3,409.

23. American Conference of Governmental Industrial Hygienists, Threshold Limit Values for Chemical Substances and Physical Agents in the Workroom Environment with Intended Changes for 1980, (Cincinnati: 1979), Appendix A, pp. 40-42.

24. Occupational Disease, op.cit., pp. 10-18

25. Ison, Accident Compensation, p. 35:

> Any compensation system will operate with a high incidence of injustice, according to its own criteria of eligibility, if those criteria depend on etiological classifications.

26. Ison, Ibid.

27. Manitoba, Accident and Sickness Compensation in Manitoba: A Government White Paper, (Winnipeg: May, 1977).