Doctor, I can't work: Medical-legal issues in disability claims

Many aspects of disability insurance claims involve medical-legal considerations. With better knowledge of these issues, you will be better equipped to address insurance issues when they arise.

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Our society defines individuals by their education and employment status, so the ability to work is critical to most people's financial survival. When health issues interfere with an individual's ability to work, they can experience losses at many levels of their lives: in addition to the loss of health and the loss of one's ability to earn a livelihood, people often experience a loss of identity, feelings that they are disappointing their family, fear for the future, and other emotional distress.

It is to protect oneself against some of these losses that most people purchase disability insurance. The courts in BC have characterized disability insurance as insurance which is designed to secure "peace of mind." In a leading BC decision, *Warrington v. Great-West,*[1] the BC Court of Appeal quoted the following passage in an Ontario decision,[2] which described the nature of an insurance contract tied to a person's health status thus: "few contracts could affect one's personal interests more than a contract for medical and rehabilitation benefits… The predominant, if not the sole object of the contract was to provide ease of mind to the insured that his medical accounts would be taken care of by timely payment during the period of rehabilitation."

Legal definition of "totally disabled"

In this context, many physicians, as well as the courts, struggle with the following questions:

- What is this person capable of doing?
- Do this person's functional limitations reasonably constitute an inability to work?

Most disability insurance policies provide that benefits are payable when the insured is "totally disabled." Different policies define "totally disabled" in different ways; some policies tie disability to an inability to generate income at a certain level, such as 60% to 75% of indexed pre-disability earnings. Others simply have a verbal definition of total disability. It is useful to get the actual wording of the policy before providing any opinion as to whether the insured is "totally disabled." Although the expanded definitions of total disability found in some policies and the literal meaning of the words "totally disabled" imply an extremely high threshold to qualify for benefits, the courts have made it clear that the concept of total disability must be given a practical and reasonable interpretation. The leading legal definition of "total disability" is found in *Sucharov v. Paul Revere,*[3] a decision of the Supreme Court of Canada. In this case, the insured was a broker who could answer telephones, take messages, and conduct other isolated aspects of his business. However, he would experience panic attacks whenever it came to meeting the demands of operating his business. The Court wrote:

"The test of total disability is satisfied when the circumstances are such that a reasonable man would recognize that he should not engage in certain activity even though he literally is not physically unable to do so. In other words, total disability does not mean absolute physical inability to transact any kind of business pertaining to one's occupation, but rather that there is a total disability if the insured's injuries are such that common care and prudence require him to desist from his business or occupation in order to effectuate a cure; hence, if the condition of the insured is such that in order to effect a cure or prolongation of life, common care and prudence will require

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that he cease work, he is totally disabled within the meaning of health or accident insurance policies."

Thus if the demands of full-time work would notably compromise a person's health, that person may well be considered totally disabled. The concept of total disability must also be considered in light of an individual's ability to secure and maintain competitive employment in the marketplace: in other words, the ability to financially support him- or herself.

Most long-term disability policies have distinctions between an initial period, where an insured is considered "totally disabled" if he or she is unable to work at his or her own occupation, and a subsequent period, where "total disability" is defined as being unable to work at any job for which the insured is qualified by virtue of his or her education, training, and experience.

When an insured person applies for long-term disability benefits, the treating physicians are invariably asked to provide information concerning the person's health status. As these enquiries are closely related to the person's ability to work, opinions are often solicited and expressed in terms of whether the person is able to work. But the two issues are quite distinct; an opinion concerning the person's health is a strictly medical question, whereas an opinion concerning the person's ability to work is much broader, requiring the following additional knowledge and information:

- Knowledge about the policy definitions of "total disability" and its legal interpretation.
- Clarification as to whether the enquiry is made during the "own occupation" period or the "any occupation" period.
- If the threshold is for the person's "own occupation," an understanding of the cognitive and physical job requirements of the individual's job.
- If the enquiry comes during the "any occupation" period, an understanding of the individual's education, training, and experience.
- An appreciation of the differences between health problems and disabilities.

If this information is not available, it is advisable to state this in a reporting letter and focus on the medical issues.

No need for "objective" medical evidence

Often when disability claimants are denied benefits, they receive a letter from the insurer advising that they did not provide sufficient objective evidence of disability. This is not a legally justifiable basis for denying disability benefits. In *Eddie v. Unum* (1999; BCJ No. 2013), the BC Court of Appeal quoted a previous decision, *Maslen v. Rubenstein* (1993; 83 BCLR [2d] 131), in which it had noted:

"It is not particularly helpful, in my view, to ask whether a psychological condition such, for instance, as the "chronic pain syndrome," is "compensable." I say this because there seems to be no settled view within the medical community as to what such diagnoses—sometimes, indeed, called 'non-diagnoses'—mean."

The court described the type of evidence which was required as follows:

"So there must be evidence of a 'convincing' nature to overcome the improbability that pain will continue, in the absence of objective symptoms, well beyond the normal recovery period, but the plaintiff's own evidence, if consistent with the surrounding circumstances, may nevertheless suffice for the purpose."

In that case, the court noted that "while the medical evidence called on behalf of Ms D.E. in support of her claim that she was disabled from working was largely dependent on her subjective description of her symptoms and their effect upon her, there was evidence from others verifying the apparent effect of her condition on her day-to-day living and her ability to work. The credibility of these witnesses was not challenged. Nor was it suggested to Ms D.E. that she was "faking" or "malingering" in order to obtain disability benefits, or for any other reason."

The code of ethics adopted by the BC College of Physicians and Surgeons requires physicians to act in the best interest of their patients

Key examples of debilitating symptoms that can disable an individual from work, but are difficult to quantify, include pain, depression, and fatigue. In other words, absence of evidence is not evidence of absence. Doctors who are requested to provide reports for patients should not be reluctant to explain that their assessment is based on all of the appropriate medical grounds: a review of tests results, the patient's history, and their clinical judgment.

Independent medical examination reports

Not infrequently, the insurer will make a patient undergo an independent medical examination (IME) following which benefits are terminated. In order to understand the basis of the insurer's decision, and if appropriate, to challenge the decision, it is necessary to review the IME report. Usually, the insurer will produce a copy to the patient's family physician. However, there are instances when the IME report is not produced. In *Parslow v. Masters,*[4] the Manitoba Court of Queen's Bench held that an insured person is entitled to production of IME reports on the basis that the patient had a personal interest in medical documentation pertaining to him- or herself. The judge relied on the principles

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set out in the Supreme Court of Canada decision *McInerney v. Macdonald*,[5] and concluded:

"While it is true that Great-West paid for the medical report in respect of Parslow, it is also true that Parslow was required to disclose private and personal information about herself to enable Masters to prepare the report. In this respect, a physician-patient relationship was created, even if the purpose of the medical consultation with Masters was not to enable him to advise Parslow and prescribe a course of treatment for her.... There is at best only a difference of degree and not of substance in the situation where the patient attends a physician for a third party medical rather than for professional services."

Ongoing demands for reports in face of chronic condition

It is no secret that most physicians are extremely busy and have limited time for the preparation of reports requested for disability insurance claims. Repeated requests for production of records or status reports requesting objective medical information concerning a patient with a chronic health problem can be frustrating. One idea would be to explain to the insurer the chronic nature of the patient's condition and the likelihood that the patient's condition will not change in the future.

Limitation periods

Limitation periods pose a significant problem for many insured patients. A limitation period is the time within which a person must commence a legal action in order to receive disability benefits. If an action is not commenced within the limitation period, the person will completely lose his or her right to claim disability benefits.

The limitation period for commencing a legal action will be governed either by the policy or legislation. It is not the practice of employees to produce copies of a group policy of disability insurance. At best, people may have benefit booklets, which are usually silent on the running of a limitation period. The policy of long-term disability insurance must therefore be specifically requested from either the employer or the disability insurer.

If there is a difference between the limitation period stated in the policy and the limitation period provided by legislation, the longer of the two periods will apply. If the legislation applies, the most common limitation period (s. 22 of the Insurance Act) requires that an action be commenced "within one year after the furnishing of reasonably sufficient proof of a loss or claim under the contract and not after." This has been interpreted by the BC Court of Appeal to mean that there must be a clear and unequivocal denial. Often, an insurer will indicate that the medical evidence is insufficient to allow it to conclude that benefits are payable. Insurers may offer to consider additional medical documentation and patients often turn to their treating physicians for additional reports and records. It is not uncommon that the process of requesting and submitting records drags on. As a general rule, because of the disastrous consequences of having an action dismissed as being "out of time," it is wise for an action to be commenced within 1 year of when proof of loss was submitted or 1 year from the date benefits were terminated.

Rehabilitation

Some disability insurance policies will provide that rehabilitative support is available at the initiative of the insurer. Often, policies with rehabilitation provisions state that benefits will be terminated if the patient does not cooperate with a rehabilitation program. It is generally the practice of insurers to seek input from treating physicians as to the appropriateness of a rehabilitation program. Two issues arise in this context:

- What is the responsibility or role of the treating physician if he or she is not comfortable with the proposed rehabilitation program?
- What happens if the patient is genuinely not able to complete the rehabilitation program?

These issues do not appear to have been clarified by the courts. What is important in this context is that the code of ethics adopted by the BC College of Physicians and Surgeons requires physicians to act in the best interest of their patients. In a Supreme Court of Canada decision *Janiak v. Ippolito*,[6] the court determined that if the plaintiff follows any one of several courses of treatment recommended by his doctors, he or she will be considered to have acted reasonably. Thus the treating physician's opinions concerning appropriate rehabilitative initiatives, if they fall within the broad spectrum of mainstream medicine, would likely mean that patients are not required to participate in rehabilitation programs not approved by their treating physicians, and their failure to complete a rehabilitation program, if due to their disabilities, would not allow the insurer to terminate benefits for that reason.

Surveillance

Insurers who are troubled about the lack of objective evidence of disability may at times resort to the use of surveillance. The governing provincial legislation is the Personal Information Protection Act (RSBC 1996, c. 63) (also know as PIPA). The governing federal legislation is the Personal Information Protection and Electronic Documents Act (SC 2000 c. 5; also known as "PIPEDA.") The general principles are that information obtained about a person must be disclosed. The only potentially applicable exception would be where the collection is reasonable for purposes related to investigating a breach of an agree-

ment. Under this provision, it is questionable whether a disability insurer would be allowed to conduct surveillance when it is still paying benefits. Where benefits have been terminated, and an action commenced, surveillance is allowed, but only on a limited basis—as a last resort, with the decision to spy being made at a very senior level. To date, few decisions have been made under either Act.

Damages for mental distress

In the *Warrington* decision, supra, the BC Court of Appeal held that because disability insurance contacts are designed to provide peace of mind, where they are breached, and the insured person suffers emotional distress as a consequence, damages for mental distress may be awarded. This is a departure from the historical position of the courts, which have held that because emotional suffering is so difficult to assess, nothing should be awarded. Legal critics have argued that where an important component of the contract includes intangible benefits, such as peace of mind, it is illogical and unjust to ignore the suffering caused by a breach of the contract. Damages for mental distress in disability insurance cases have traditionally ranged from nothing to $20 000. At the present time, Sun Life is appealing this line of cases in the decision *Fidler v. Sun Life,*[7] a case which is scheduled to be argued before the Supreme Court of Canada this December. Sun Life is alleging that in order to recover under this head, it is necessary to prove that the insurer committed an "independent actionable wrong," something in addition to not paying benefits. The argument on behalf of Ms Fiddler is that a wrongful decision to deny benefits often causes exceptional suffering because these patients are already struggling with physical or emotional illnesses and then face increased financial and/or emotional turmoil as a result of the denial of disability benefits.

Punitive damages

In a 2002 Supreme Court of Canada decision *Whiten v. Pilot Insurance Company*,[8] the law concerning punitive damages was given much greater prominence. In that case, which involved a fire insurance claim, the insurer had refused to pay insurance proceeds in the face of essentially undisputed evidence that the insured had not caused the fire and was entitled to the insurance proceeds. It was also clear that Ms Whiten needed the insurance funds in order to purchase another home. The Supreme Court of Canada upheld a $1 million jury award against the insurance company on the basis that it would deter insurers from improperly denying legitimate claims. The Court emphasized that insurance companies were under an obligation to adjudicate claims fairly and in good faith. These principles were applied in a disability insurance claim in *Fidler,* supra, where the BC Court of Appeal awarded $100 000 against the insurer for improperly withholding benefits for approximately 5 years, and only reinstating benefits 1 week before trial.

References

1. *Warrington v. Great-West* (1996), 139 DLR (4th) 18 (BC Court of Appeal).
2. *Thompson v. Zurich Insurance Co.* (1984), 7 DLR (4th) 664 (Ont. High Court).
3. *Sucharov v. Paul Revere* (1983) 2 SCR 541.
4. *Parslow v. Masters* (1993) SJ No. 210 (Sask. QB).
5. *McInerney v. MacDonald* (1992) 2 SCR 138 (SCC).
6. *Janiak v. Ippolito* (1985) 1 SCR 146 (SCC).
7. *Fidler v. Sun Life Assurance Co. of Canada* (2004) BCJ No. 982 (BCCA).
8. *Whiten v. Pilot Insurance Co.* (2002) 1 SCR 595 (SCC).

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partly based on a rapport that has been established with the patient over time. In a hospital setting, time to establish rapport is often limited by the need to make immediate medical decisions and the patient's emotional support is lost. In the event of cardiac arrest, hospital caregivers require guidelines and look to the attending physician to designate whether a patient is to be resuscitated. In such a case, the family physician often is better able to speak with the patient or designated family member about this issue. The topic of resuscitation may have previously been discussed in the office setting or the patient may have provided the doctor with a living will outlining his or her wishes. These circumstances can make it much easier for the family physician to address this issue in a way that is less emotionally distressing for the patient. Knowing a patient only a short time, hospitalists cannot possibly hope to broach the subject of "do not resuscitate" in as empathetic a manner as a patient's family doctor. Invariably, if there is some urgency to making the decision, the discussion with the patient or family member seems businesslike and somewhat cold.

For many patients and family members, the "do no resuscitate" discussion in the emergency setting is an emotionally distressing experience and is better carried out by their family physician.

Conclusion

From the perspective of the needs of the patient, there are advantages to family physician care of hospital patients. While the hospitalist program might better meet the needs of hospital staff requiring easy access to an "in-house" attending physician, the hospital patient is better served when he or she is treated by a family doctor.