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THE THERAPEUTIC SIGNIFICANCE OF COMPENSATION STRUCTURES

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This article deals with the therapeutic significance of claims for damages and other types of compensation, and of the processes relating to claims. It examines the influences of legal structures and processes in promoting the recovery of a patient/client from disablement, or in alleviating or aggravating the development of a disability. It is concerned in particular with the spill-over influences of claims on the formation of medical opinions, on the selection of treatment, on patients' responses to treatment, and on rehabilitation.

The article examines the assumption that compensation systems promote a widespread psychological problem of "secondary gain", "monetary gain", or "compensation neurosis". The author explains why the assumption exists and he examines its validity.

The article provides a commentary relevant to the conduct of claims, and it also seeks to identify the therapeutic significance of structural alternatives in the design of compensation systems.

L'auteur de cet article traite de la signification thérapeutique des recours en dommages-intérêts, ou autres types d'indemnisation, et des procédures relatives à ces recours. Il étudie la part d'influence des structures et procédures juridiques dans le processus de guérison des dommages corporels subis par le patient ou client, c'est-à-dire dans l'allègement ou l'aggravation du développement de son invalidité. Il s'intéresse en particulier à l'expansion de cette influence juridique, tant sur la formation des opinions médicales et sur le choix du mode de traitement que sur la réponse des patients au traitement et sur la réhabilitation.

L'auteur examine l'hypothèse que les systèmes d'indemnisation suscitent très fréquemment un problème psychologique de "profit secondaire", de "profit financier", ou "névrose d'indemnisation". L'auteur explique l'existence de cette hypothèse et en scrute la validité.

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L'auteur fournit ainsi un commentaire pertinent concernant la conduite de ces réclamations d'indemnité, tout en cherchant à déterminer la valeur thérapeutique de types de solutions différents dans la conception des systèmes d'indemnisation.

I. General Significance

A. Introduction

Lawyers are accustomed to perceive of their relationship with the medical profession as one in which physicians are expert witnesses, playing an ancillary role in legal processes. The purpose of this article is to view the process of medico-legal interaction from the opposite perspective; to examine legal structures in terms of their significance for medical care and rehabilitation. Does a patient's receipt or expectation of damages or other compensation for disablement affect the way in which physicians form opinions on diagnosis or etiology? Does it operate to alleviate or aggravate the incidence of disablement? Does it affect the prescription of treatment, or patients' responses to treatment? Do structural or operational features of legal systems relating to claims for compensation have any influence on diagnosis, on opinions relating to etiology, on the incidence of disablement, on treatment or the response to treatment? These are some of the questions that prompted this article.

The research for this work has included a review of medical, legal and social science literature, augmented by attendances at places of medical treatment, by interviews with physicians and other treatment personnel, and with patients. While the fieldwork was done predominantly in Canada, the literature searches included other Commonwealth countries, the United States, and Scandinavia. This has extended the input of information and ideas and has permitted confirmation on many points, but it has of course the disadvantage that some of the observations that follow may not apply in the jurisdiction of particular interest to the reader.

Much of this discussion might appear relevant to the discipline of medicine rather than law, but there are substantial reasons for lawyers to take more than a passive interest. First, it is important for practising lawyers to understand the significance of what they do in terms of its impact on the medical care and rehabilitation of their clients. Secondly, an academic lawyer may have a better vantage point than a physician from which to envisage the solution of problems through changes in legal structures.

This article relates primarily to tort liability and workers' compensation, though much of the discussion is also relevant in the context of automobile accident plans, long-term disability insurance, sick pay, and other systems of compensation.

One conclusion to emerge from this research is that claims for compensation and the processes of pursuing claims are not a major influence

on the course of a disability in most cases. More significant variables include the nature of the organic disability, its significance for vocational opportunities, the capacity of the medical profession in relation to diagnosis and treatment, pre-morbid job satisfaction of the patient, family support, and other cultural, personal, environmental and economic factors. Nevertheless, claims for compensation and the processes relating to them are a significant influence on the development of many disabilities and a major influence on some. It is important in any discussion of system design, therefore, to consider the significance of alternative structures in terms of their influence on medical care and rehabilitation.

While much of this article relates to psychological disability, compensation structures may have a significant influence on medical opinions relating to diagnosis and etiology, even with regard to organic disabilities.

B. Influence on Diagnosis and Opinions on Etiology

Forming an opinion on diagnosis and etiology can require an oral as well as visual examination of the patient. The oral examination may relate to how, when and where the injury occurred, contemporaneous and subsequent symptoms, and any prior history of problems in the same part of the body. In a disease case, the inquiry may relate also to exposure history. In this context, a compensation system that is etiologically based, such as workers' compensation or tort liability, creates an obvious incentive for a patient to have disabilities attributed to a compensable cause. This might influence the selection and emphasis with which a patient informs an examining physician of the facts.¹ In some cases, the influence of a compensation system might go further to produce wishful thinking, the concealment of relevant facts, or lies. Conversely, suspicion in the mind of an examining physician that a patient is influenced by monetary gain might result in a patient being disbelieved when he is telling the truth. The proportion of cases in which such a question of credibility might arise is not a fringe minority. Indeed, probably about one-third to one-half of claims for workers' compensation involve disabilities in respect of which an opinion on diagnosis and etiology depends, wholly or primarily, on the facts related by the patient.

An aggravating factor is that some of the traditional ways of testing the credibility of claimants can be useless and counter-productive. For example, a common method is to compare the symptoms of which the patient complained immediately following trauma with those of which he complained later. The mention of a new symptom later is often viewed as cause for suspicion. Yet pain resulting from trauma may not be felt instantly. A traumatic experience can have a numbing effect, or an injury may be sustained in circumstances that create distractions. Later, when

¹ See, e.g., H.D. Lomas and J.D. Berman, *Diagnosing for Administrative Purposes: The Process and Problems* (1982), 23 *Comprehensive Psychiatry* 545.

the numbing effect has worn off, or the distractions have discontinued, the pain is felt. Also the contemporaneous statement of symptoms may be abbreviated or edited by the person making the record, often a first-aid attendant. Later, the patient may be making the same complaints but they are more fully recorded. There is often a reluctance on the part of adjudicators, or those opposing a claim, to accept that the pain of which the patient complained subsequently, or which was only recorded subsequently, is genuine and attributable to the trauma because "he never complained of that at the time".

Compensation systems also create suspicions of and among different sectors of the medical profession. The opinions of general practitioners are often discounted by an assumption that they are lenient to their patients or gullible, while the opinions of company doctors, workers' compensation board doctors or insurance company doctors are often attributed to a bias against compensation.

There are also more systematic ways in which compensation systems impair the receipt of relevant information by attending physicians. For example, the risk of compensation claims is one of the reasons for resistance in the political process to any regulations that would require content labelling of industrial chemicals. Without such labelling, a patient may be unable to inform his physician of any relevant exposure history. Similarly the risk of tort liability is one of the reasons for resisting patients' rights to their medical records. Yet the clinical findings of an attending physician may never reach another physician subsequently dealing with the same matter unless they are communicated via the patient, particularly if the patient has moved to a new area. Again, the risk of compensation is one of the reasons why some companies have sometimes withheld evidence of occupational disease from the workers affected.² In many and probably most such instances, where the information is not available to the patient and hence not communicated by the patient to the advising physician, it will not reach that physician in any other way.

Compensation systems that are etiologically based also contribute in other ways to the under-recognition of occupational etiology in disease cases.³ For example, a positive opinion by an attending physician on diagnosis and etiology is generally subject to scrutiny in the process of claims adjudication. Commonly a negative opinion or no opinion is not. Similarly in medical literature, positive medical opinions on the indus-

² See, *e.g.*, Brief of the United Steelworkers of America to the Royal Commission on the Confidentiality of Health Records (April 1978, Ontario), p. 23.

³ It has been estimated in the United States that "[o]nly five percent of those severely disabled from an occupational disease receive workers' compensation benefits": U.S. Department of Labour, *An Interim Report to Congress on Occupational Disease* (1980), p. 3. This picture is not confined to the U.S. See, *e.g.*, T.G. Ison, *The Dimensions of Industrial Disease* (1978, Industrial Relations Centre, Queen's University, Ontario).

trial etiology of a disease are likely to be subjected to close scrutiny. Comparable resources are not always allocated to the scrutiny of negative opinions. The prospect of compensation appears to stimulate a body of negative or over-cautious etiological literature, and this in turn is reproduced in the standard medical texts. For example, if it were not for the prospect of compensation, it would probably have been recognized more readily that bronchitis and emphysema can result from employment exposures. Moreover, some "medical" literature is written avowedly for the purpose of reducing compensation costs.⁴

Another factor contributing to the under-recognition of occupational disease is a propensity in many members of the medical profession to believe that for a disability to be compensable under an etiologically-based system, a positive opinion requires that occupational causation be established with certainty, or at least with a high degree of probability. There is a reluctance to accept the balance of probabilities usually prescribed by law, and a reluctance to accept the usual criteria of the medical profession.⁵ This has even been carried to the point of recommending that an invasive surgical procedure be used to clinch the matter, notwithstanding that an affirmative opinion on diagnosis and etiology is already warranted by other data as the best available hypothesis.

Even if the clinical and roentgenographic findings are typical of a specific pneumoconiosis, lung biopsy is sometimes advisable for medicolegal determinations of the cause of the disability.⁶

Similarly it is sometimes asserted in "medical" literature that an affirmative opinion on occupational etiology cannot be given unless exposure records are available. For example:

Unless the otologist has knowledge of the employee's occupational history and time weighted average of noise exposure he cannot make a valid diagnosis of OHL [occupational hearing loss].⁷

As a practical matter, such exposure records are seldom available for the relevant past time periods, and if available, are often of unknown accuracy.

To the extent that compensation structures induce errors in medical opinions, either directly or via medical literature, the results for a compensation system are obvious. They include the denial of claims and the failure to file claims where compensation is lawfully due, and the payment of compensation that is not lawfully due. The consequences, how-

⁴ See, e.g., J. Sataloff, *WC Hearing Loss Claims Should be Handled With Care*, [March 1984] *Occupational Health and Safety*, p. 35.

⁵ See, e.g., (1) G.A. Lillington and R.W. Jamplis, *A Diagnostic Approach to Chest Diseases* (2nd ed., 1977), p. 365; (2) H.C. Hinshaw, *Diseases of the Chest* (3rd ed., 1969), c. 37. There is, of course, also an understandable and legitimate reluctance to reach a positive diagnosis when a disease would inevitably be terminal; *ibid.*, p. 433.

⁶ Lillington and Jamplis, *ibid.*, p. 365.

⁷ Sataloff, *loc. cit.*, footnote 4, at p. 35.

ever, go beyond compensation decisions. In particular, under-recognition of the occupational etiology of disease is a negative influence on prevention. Though probably less frequently, an erroneous opinion on diagnosis or etiology can also result in an erroneous prescription of treatment.

C. Treatment

Compensation can also be relevant to treatment in other ways. In particular, it can operate to limit the treatment choices of claimants. For example, some physicians strive to avoid automobile accident cases, or workers' compensation cases, sometimes because of the time that may be involved in subsequent controversies. Again, it has been estimated that only about twelve psychiatrists out of over three hundred in Metropolitan Toronto are willing to deal with the Workers' Compensation Board.⁸

The control exercised by some workers' compensation boards over elective surgery has also been a restraint on patient choice, though on the whole this restraint has probably been beneficial. In particular, the boards played a leading role in saving patients from unnecessary and damaging back operations. Occasionally, however, it is alleged that this restraint goes too far.⁹

II. Legal System Etiology in Non-Organic Disablement

A. Introduction

Probably the greatest medical significance of the receipt or denial of compensation, or the expectation of compensation, or various features of compensation systems, lies in the creation, aggravation or alleviation of neurotic or other psychological disorders.

There is no doubt that the receipt of compensation is generally a positive influence. Indeed, it can be seen as an essential first step in successful rehabilitation.¹⁰ For example, among workers' compensation claimants whose disabilities are not disputed or disputable, such as the paraplegics and the amputees, the prompt commencement of compensation payments relieves the financial concerns that form part of the anxieties commonly suffered by others with similar disabilities. Conversely, the denial of compensation can obviously be a cause of anxiety and depression. This can be aggravated for a claimant who applies successively under several compensation systems and receives a series of deni-

⁸ From an official source.

⁹ For example, in Ontario there is a controversy about the refusal of the Board to recognize the sclerosing of ligaments as a legitimate treatment for certain low back conditions.

¹⁰ See, e.g., C.G. Magee, United Kingdom: Determination, Evaluation, and Rating of Disabilities (1961), 30 *Industrial Medicine and Surgery* 46, at pp. 46 and 47.

als, perhaps because the disability does not qualify under the perimeter rules of each system.

Most medical literature on the subject, however, refers to the negative potential of compensation, particularly in relation to "secondary gain". This phenomenon might be described as the subconscious development, exaggeration or prolongation of disability symptoms in response to some benefit or expectation of benefit. The benefit may take a variety of forms, such as family compassion or relief from duties.¹¹ For present purposes, however, the relevant benefit is monetary compensation,¹² and where this is the case, the phenomenon might be described as "monetary gain". It differs from fraud or malingering in that the symptoms described by the patient are genuinely felt, and the link between the gain and the symptoms is not a process of conscious reasoning. Sometimes the term "compensation neurosis" is used to describe this phenomenon, but that term is also sometimes used in relation to psychological problems resulting from the process of claiming compensation rather than the receipt or expectation of payment.

Apart from disease cases, compensation neurosis and monetary gain seem to be the area in which compensation systems have the most widespread influence on opinions relating to diagnosis and etiology.

The medical literature includes various classifications and descriptions of psychological conditions following trauma, or that are otherwise associated with disability or with compensation.¹³ For present purposes, they can be referred to collectively as psychological disorders. In workers' compensation files¹⁴ and elsewhere these disorders have commonly been referred to by the non-diagnostic, non-descriptive, and insinuating phrase "functional overlay".¹⁵

Every significant disability has a psychological component which may interact with organic causes of pain, possibly with synergistic effect, in ways that are seldom obvious. Moreover, it is part of contemporary thought in the medical profession that the psychological component in a disability may develop as an independent disease entity, continuing even beyond the duration of the organic cause.¹⁶ This is sometimes referred to

¹¹ See, e.g., S.Z. Nagi and L.W. Hadley, *Disability Behavior: Income Change and Motivation to Work* (1971-72), 25 *Industrial and Labor Relations Rev.* 223.

¹² See, e.g., S.F. Brena *et al.*, *Conditioned Responses to Treatment in Chronic Pain Patients: Effects of Compensation for Work-related Accidents* (1979), 44 *Bulletin of the Los Angeles Neurological Societies* 48.

¹³ See, e.g., L. Keiser, *The Traumatic Neurosis* (1968).

¹⁴ See, e.g., T.G. Ison, *Information Access and the Workmen's Compensation Board*, Research Publication No. 4, 1979, Commission on Freedom of Information and Individual Privacy, Ontario, p. 93.

¹⁵ See, e.g., M.R. Trimble, *Post-Traumatic Neurosis* (1981), p. 53.

¹⁶ Lecture by Hamilton Hall to the Civil Justice Section, Canadian Bar Association,

as "chronic pain syndrome". If such a disease exists, however, it is questionable to what extent this and other psychological disorders following injury should be attributed to monetary gain.

B. Dubious Attribution of Monetary Gain

There are two broad categories of compensation claimants who appear to cling to their disabilities as a source of income, and who might be perceived as justifying a perception of monetary gain as widespread:

- (1) Those who want to work but have no job to return to and no prospect of employment. This group is a large one when unemployment is high.
- (2) Those who are worn down and no longer fit for the manual jobs that have been their lifestyle.

With regard to the second group, people do not begin their working lives with uniform physique, nor do they age at a uniform rate. Some are fit for heavy work into their eighties while others find it beyond them when they have reached their forties. Someone who suffers a significant back disability at the age of say fifty-three may find that he cannot qualify for retirement or disability income, nor can he find any available light work. His only hope of obtaining income while avoiding welfare lies in a compensation claim.

To whatever extent these situations create psychological disorders, it would be more of a political choice than a medical opinion to attribute them to a desire for compensation. These disorders could equally well be attributed to a lack of alternatives; and if a humane solution is to be found through changes in system structure, that must be the attribution.

To apply a diagnostic label, such as "monetary gain", "secondary gain", "compensation neurosis" or "functional overlay", to people in these two groups serves no curative purpose. Indeed, the patronising and insinuating character of the label can increase the stress. Another significance of these "diagnostic" labels in these situations may be to distribute the resulting economic losses according to the political judgments of those who apply the label.

C. Exaggerated Estimates of Monetary Gain

Apart from the two categories mentioned under the previous heading, there are no reliable quantitative data and no other evidence known to the writer of any widespread incidence of disability symptoms resulting from monetary gain. There are some studies showing that workers' compensation claimants take longer to recover than other patients with similar

Toronto, November 1983. See also A. Magora, *Investigation of the Relation Between Low Back Pain and Occupation* (1973), 5 *Scandinavian Journal of Rehabilitation Medicine* 191.

disabilities,¹⁷ and from these data an inference has been drawn that monetary gain is widespread. These studies, however, do not appear to control for other relevant variables, such as occupation. Yet the demands of a job are a key variable in the determination of fitness for work. A corporate executive who breaks a leg becomes an executive with a leg in a cast, but an ironworker who breaks a leg may legitimately have to abstain from his usual occupation until the fracture has healed.

There are other reasons, too, why some categories of compensation claimants may take longer to recover and which have nothing to do with compensation. For example, the perception of work as causative may be significant. Regardless of compensation, a bricklayer's labourer who knows that his work caused his painful back condition can be expected to show more caution in returning to that work than a young insurance broker who suffered the same injury on a rugby field and who knows that his work had no causative significance.¹⁸ This factor may help to explain why immigrants, who are found in disproportionate numbers in high-risk occupations, are commonly perceived as more prone than native-born workers to psychological impairment in bad back cases.¹⁹ Again, it could be the process of obtaining compensation, rather than the receipt or expectation of the money, that tends to delay recovery in some cases.

Feelings of rage, aggression, fear, guilt, and other strong feelings engendered by the accident are exacerbated by negotiations over workmen's compensation, resulting in increased psychic tension, which can increase symptoms. Although reflected as a generalized response in the whole body, it is most keenly felt in the low back muscles . . .²⁰

Experience rating can be another negative influence. Often it stimulates the development of schemes under which employers reward supervisors, foremen or workers for the absence of reported injuries. When an injury threatens the loss of any such reward, some resentment against the injured worker may occur, particularly in a case of soft tissue injury. This resentment can be another factor discouraging a return to work.

For all of these reasons, it would be absurd to use data showing only that compensation claimants take longer to recover than other people with similar disabilities as evidence that compensation claimants are motivated

¹⁷ See, e.g., E.M. Krusen *et al.*, Compensation Factor in Low Back Injuries (1958), 166 *Journal of the American Medical Association* 1128; W. Hammonds *et al.*, Compensation for Work-Related Injuries and Rehabilitation of Patients with Chronic Pain (1978), 71 *Southern Medical Journal* 664; Brena, *loc. cit.*, footnote 12.

¹⁸ For a discussion of social class variables that may also influence a return to work, see T. Honig-Parnass, The Relative Impact of Status and Health Variables Upon Sick-Role Expectations (1983), 21 *Medical Care* 208, at p. 222.

¹⁹ See, e.g., A. Rubinstein, Mediterranean Back and Other Stereotypes: A Review of the Australian Literature Dealing with Industrial Back Injuries (1982), 17 *Journal of Social Issues* 295.

²⁰ Keiser, *op. cit.*, footnote 13, p. 147.

by monetary gain. Moreover, there are other studies suggesting that rates of recovery from disability are not significantly different as between those receiving or claiming compensation and those with similar disabilities in similar occupations who are not receiving or expecting compensation.²¹

The anecdotal evidence reporting the most widespread incidence of monetary gain comes from psychiatrists and other medical specialists who see only a small pre-selected sample of hard cases. The writer has been advised by physicians who see a more representative sample of workers' compensation claimants, particularly the administrators of workers' compensation board clinics, that the majority of claimants want to recover and return to work²² and only a minority (probably about ten per cent) do not. Even those physicians only see a sample that is weighted in favour of the hard cases, and many of the ten per cent minority within that sample could be de-motivated by factors other than monetary gain; in particular, no job to return to and the lack of available employment for which they are suited.

A diagnosis of monetary gain, secondary gain, or compensation neurosis is commonly not a positive diagnosis supported by any apparent symptoms, but a diagnosis reached by exclusion. Medical literature, medical opinions, and the medical conclusions of courts and administrative tribunals commonly recognize only two broad etiological categories:

- (1) diagnosed organic causes, and
- (2) psychological causes.²³

In this contextual framework, complaints of pain or other symptoms of disability that do not result from any diagnosed organic cause must result from a psychological cause, probably monetary gain, or the patient is malingering. Indeed, there is a remarkable correlation in the medical literature between the use of this twofold etiological classification and the perception of monetary gain as widespread.

There is, however, recognition in some of the medical literature, and perhaps growing recognition, of a third broad etiological category, that is non-diagnosed organic cause. Moreover, this category may be a large one. The records of workers' compensation boards include many cases initially perceived as psychological or as malingering, and which are subsequently diagnosed as organic disabilities.²⁴ There have also been

²¹ See, e.g., C.V. Horn and A. Glass, *Analysis of Factors Concerned with Delay in Return to Work After Injury and Their Relation to Claims for Compensation* (1971), 3 *Injury: The British Journal of Accident Surgery* 9.

²² For other research supporting the view that disabled people generally want to return to work regardless of economic need, see Nagi and Hadley, *loc. cit.*, footnote 11.

²³ See, e.g., V.J. Derebery *et al.*, *Delayed Recovery in the Patient with a Work Compensable Injury* (1983), 25 *Journal of Occupational Medicine* 829.

²⁴ Many such examples are within the experience of the writer.

some quantitative estimates. In one sample studied, it was found that twenty-five per cent of the cases initially diagnosed as psychological were subsequently diagnosed as organic disabilities, and in another sample it was forty-eight per cent.²⁵

The conditions most often mislabeled as hysteria appear to be those involving degenerative conditions affecting skeletal, muscular, and connective tissues, the spinal cord and peripheral nerves.²⁶

Another circumstance from which an inference of monetary gain is sometimes drawn is that compensation claimants sometimes present themselves for treatments, such as physiotherapy, to an extent beyond that which is required as a response to any diagnosed organic disability. Part of the explanation here, however, may be that the attendances are not the choice of the patient but are required, or thought to be required, for benefit control purposes by a compensation board or insurance company.²⁷

Again, it has been alleged in defence literature that compensation neurosis (including monetary gain) is usually inversely proportionate to the gravity of any organic disability.²⁸ Yet the category of cases in which monetary gain is commonly believed to occur on the broadest scale is that of bad backs. A notorious feature of these cases is that attending physicians commonly perceive of the disabilities as minor (which in some ways may be correct) while the patients commonly see them as major. Indeed, these conditions are sometimes perceived by patients as threatening an end of their employment capabilities. If a patient understands a physician to perceive as minor a condition which the patient is convinced is a major disability, this factor alone could explain why a patient may proceed to exaggerate his symptoms.

Also in bad back cases, the difficulty in arriving at a diagnosis is sometimes accompanied by difficulty in responding to the pleas of the patient for curative treatment. It is an observable phenomenon in the medical profession, as well as in the legal profession, that there is sometimes a propensity to turn on a client who presents a problem that the professional is unable to solve—to perceive of this client as something of a nuisance, and perhaps also to perceive of the problem as psychological.²⁹

²⁵ C.G. Watson and C. Buranen, *The Frequency and Identification of False Positive Conversion Reactions* (1979), 167 *Journal of Nervous and Mental Disease* 243, at pp. 244-246.

²⁶ *Ibid.*, at p. 246.

²⁷ In some insurance policies, it is a condition of eligibility for continuing benefits that the claimant be under the care of a physician, and insurance companies have been known to invoke this clause as a ground for terminating a claim even in a case where further medical care for the disability may be useless. See, e.g., *Taaffe v. Sun Life Assurance Co. of Canada* (1979), 100 D.L.R. (3d) 133, at p. 145 (Ont. H.C.).

²⁸ See, e.g., H. Miller, *Accident Neurosis*, [1961] *British Medical Journal* 919, at pp. 992-998.

²⁹ See, e.g., B.E. Finneson, *Low Back Pain* (2nd ed., 1981), p. 180.

Lastly, medical literature and opinions often reflect the socio-economic and political views of the authors, and sometimes these include a disdain for the provision of unearned income or damages to working people.³⁰ This may contribute not only to the misdiagnosis of organic disabilities as psychological, but also to the increase of psychological disorders.

If the patient feels that his doctor is tending to minimize damage claims because of indifference or, worse, because of a loyalty elsewhere, a genuine and substantial barrier to the patient's recovery is produced.³¹

If disability symptoms resulting from monetary gain really were widespread, one would expect the symptoms to disappear after the receipt of damages or other compensation. When this does not happen, it is commonly explained on the ground that the symptoms must have become entrenched rather than as an indicator that the initial diagnosis of monetary gain was wrong. Psychiatric opinions to the effect that the condition will be cured by a monetary award are commonplace, and so too are decisions of courts and administrative tribunals to that effect.³² Yet there appears to be no substantial evidence that this happens to any significant extent. Quantitative studies have been equivocal, some showing some alleviation of the symptoms after a monetary award, others showing that the symptoms continued.³³ The weight of the evidence, however, supports the view that the symptoms commonly continue.³⁴

Anecdotal evidence is hard to evaluate because many of the medical, legal and other professionals who see patients during the recovery and

³⁰ For a classic example, see J. Collie, *Malingering and Feigned Sickness* (2nd ed., 1917):

Many a self-indulgent and lazy fellow, who never had an honest impulse for genuine hard work, seizes the opportunity which a slight accident affords to convince himself, consciously or unconsciously, that he need not work. (p. 15).

Surely it is the duty of medical men to help the State to count amongst her citizens the maximum number of units capable of working. . . . Actions for damages carry in their train, in a large proportion of cases, a moral degradation of the working-man which is truly pitiable. (p. 30).

³¹ M.H. Miller and C. Fellner, *Compensable Injuries and Accompanying Neurosis: The Problem of Continuing Incapacity Despite Medical Recovery*, [1968] *Wisconsin Law Rev.* 184, at p. 190.

³² See, e.g., *Slipman v. London Transport Executive*, 1951, Court of Appeal No. 207, reported in D.A. Kemp and M.S. Kemp, *The Quantum of Damages in Personal Injury Claims*, vol. 1 (1954), p. 361. Since issues of this kind are generally perceived as relating to "the facts", they are not commonly discussed in the appellate judgments that reach the law reports.

³³ See, e.g., Trimble, *op. cit.*, footnote 15, p. 114; Keiser, *op. cit.*, footnote 13, pp. 59-60; J.I. Balla and S. Moraitis, *Knights in Armour: A Follow-up Study of Injuries After Legal Settlement*, (1970), 57(2) *Medical Journal of Australia* 355; W.A.R. Thomson, *Accident Neurosis* (1982), 22 *Medical Science and Law* 143; I. Macnab, *The Whiplash Syndrome* (1973), 20 *Clinical Neurosurgery* 232, at p. 234.

³⁴ See, e.g., G. Mendelson, *Not "Cured by a Verdict": Effect of Legal Settlement on Compensation Claimants*, (1982), 69(2) *Medical Journal of Australia* 132.

litigation phase of a disability commonly lose contact once the compensation claim has been resolved. Hence their opinions may not be well informed. Even where the contact is maintained and there is continuing observation, it would be a mistake to assume that an end of complaints about the symptoms indicates a cure. It may indicate only that the point of complaining is now gone. Similarly if a patient was attending a psychiatrist, not in the expectation of cure, but on referral, perhaps initiated by a lawyer, to secure the psychiatric reports necessary to prove the claim, the discontinuance of those attendances when that purpose has expired would not indicate any cure of the disability.

One aspect of this, relevant to practising lawyers and claims' adjudicators, is that medical opinions in this subject area must often be scrutinized and questioned to determine whether they reflect an intelligent and sensitive diagnosis in the particular case, or whether they contain a standard response, merely reflecting the cultural environment, the economic and political outlook, and the value preferences of the physician.

D. Significance of the Assumption that Monetary Gain is Widespread

If it is correct that the extent of monetary gain is grossly overestimated, this is harmful in several ways. First, the misdiagnoses in individual cases may produce erroneous decisions on treatment. Secondly, where the condition is wrongly determined to be non-compensable, and this is generally the case where the condition is perceived as monetary gain, there is injustice in the denial or under-estimation of compensation. Thirdly, there is the therapeutic damage done by the "diagnosis" itself in the individual case. Fourthly, the belief that monetary gain is widespread appears to result in system practices being established which are themselves a cause of therapeutic damage. These last two points require further comment.

One consequence of the belief that monetary gain is widespread is a pervasive practice of treating every compensation claim with suspicion, except where the claim relates to a diagnosed organic disability and the reaction of the patient is within the normal range of expected reaction. This practice is commonly alleged against some company doctors, workers' compensation boards and insurance companies.³⁵ In workers' compensation in Canada, the practice is found among industries that are subject to experience rating. Sometimes this suspicion leads to proposals for treatment that would be so insulting and humiliating to patients that if the proposed treatment were adopted it would be bound to increase anxiety and resentment. For example:

It is further suggested that ambulatory benefits recipients might be required where possible, to report to the employers' health unit and spend the workshift sitting idly,

³⁵ For example, "The WCB starts from the premise that the guy is lead swinging"; per the director of a rehabilitation clinic in Ontario.

while not working. This could possibly serve to deter those who are capable of gainful employment from abusing compensation.³⁶

If a patient is treated in this manner, or is treated with suspicion in any other manner at his place of employment, any repetition of the suspicion by a workers' compensation board or insurance company can be particularly damaging. As a family doctor explained in an interview: "It weighs heavily on patients if no one believes them." It should be no surprise if a patient who is constantly disbelieved begins to exaggerate his symptoms. Moreover, the symptoms may actually become more severe because the anger and anxiety resulting from the disbelief can enhance the pain. Thus before long, a diagnosis of malingering can produce a psychological disorder and a diagnosis of "functional overlay" can become a self-fulfilling prophecy.

Even when a physician believes the patient, lack of a diagnosis and lack of precision in the prescription of treatment may leave the patient with a feeling that he has been disbelieved. This is particularly so if the patient is told to return to work by a physician who has not made a sufficiently thorough examination to give any reliable advice and who has not informed the patient of any diagnosis.

Again, the etiological classifications used in compensation systems play a damaging role. In the bad back cases in particular, there is often a consensus on the existence of the disability. Conflict arises from the belief of the patient that the disability resulted from employment, while a workers' compensation board or its consultant attributes the disability to spondylosis or osteoarthritis. Since the patient never felt such excruciating pain prior to an event that occurred in the course of employment, he now feels that he is the victim of injustice as well as a bad back. It should be no surprise if this creates or aggravates emotional problems. When the reaction to this is unsympathetic and the patient discovers that his condition has now been re-diagnosed as partly emotional, the incapacity may be entrenched.

These problems do not disappear after a claim has been allowed. For example, one claimant interviewed by the writer was intensely disturbed, several months after the accident, because she had been told by a workers' compensation board rehabilitation counsellor that her claim had only been allowed by giving her the benefit of the doubt. Understandably, she interpreted this as if she had been branded "suspected of dishonesty".

Similar problems can arise later in the conduct of a claim. Indeed, some physicians perceive most compensation cases with ongoing suspicion.

³⁶ D. Schlenoff, *Obstacles to the Rehabilitation of Disability Benefits Recipients* (1979), 45:2 *Journal of Rehabilitation* 56, at p. 58. It is alleged by union officials that the recommended practice is sometimes adopted in Canada, but I am not familiar with any itemized documentation. Workers' compensation boards generally condemn the practice as incompatible with sound rehabilitation.

As early recognition is imperative, successful treatment of such a patient [that is, one with a disability disproportionate to any apparent organic cause] requires that the physician have a high index of suspicion when dealing with a compensable injury of any kind. Chronicity in compensable injury cases should be considered psychogenic unless the failure to recover can be clearly explained as the normal response to physiologic insult.³⁷

Apart from being unscientific, such an approach is bound to be sensed by the patient, and is surely bound to inflict therapeutic damage.

Among Workers' Compensation Board doctors in Ontario, there now appears to be a consensus that a patient should never be told that "it's all in your mind". Complaints that Board doctors actually say this to patients have dwindled in recent years, but patients often still sense that message. The damage can be aggravated if a patient is offered a lump sum settlement for a transitory psychological disorder (with the inference that the disorder will be cured following payment) when the patient is convinced that the disability is organic.

When people are told that they will get better once they have been paid, it increases stress, because it involves the insinuation of fraud unless the doctor spells out that the bureaucratic process is causing the stress.³⁸

It is important also to understand the context in which the suspicion can impact on a patient. In a bad back case, for example, the patient is often frightened and depressed. He feels the pain and knows that it is genuine, and he has been offered no cure. He is fearful that he may no longer be able to cope with his job. His perception of his self-worth may have been downgraded by reactions at work and at home, and his recreational life is in suspense. To gather the impression now that he is perceived by people in authority as a malingering liar can be the last straw in a series of shattering blows.

When suspicion results in a denial of benefits, the denial and its economic consequences can produce further emotional stress. Indeed, in connection with disability insurance, it is now well recognized by some courts in the United States that a refusal by an insurance company to pay money when it is due can cause an emotional reaction, which is itself a compensable disability. Thus a claimant can sometimes recover not only the money due under the policy, but also exemplary damages for the emotional distress resulting from the earlier refusal to pay.³⁹

³⁷ Derebery, *loc. cit.*, footnote 23.

³⁸ Interview with a caseworker in a disabled people's organization.

³⁹ For a discussion of some of these cases, see G.O. Kornblum, *The Role of the Life, Health and Accident Insurer's Medical Director in Extra-contract Claims Litigation* (1979), 62 *Transactions of the Association of Life Insurance Medical Directors of America* 61.

E. *Multiplication of Physicians*

Any general attitude of suspicion may combine with other features of some compensation systems (such as a reluctance to accept equivocal evidence, including equivocal medical opinions) to produce another major cause of psychological harm, that is, multiplication of the number of physicians involved. It is well accepted in the medical profession that increasing the number of physicians who examine a compensation claimant is itself a cause of psychological damage.

... what of the unfortunate workman whose injury is more disabling, shows little evidence of symptom remission, and demonstrates only equivocal objective signs? ... The answers to these questions are too often sought by bringing more experts into the case ...

Questions are then asked of the patient in a manner that suggests the patient may be malingering; needs less medication than he is actually taking; could really work in a more limited capacity if he were motivated to do so; is really looking for a free ride because of his disability; has seen too many doctors; or is possibly a bit "psychiatric".⁴⁰

No small part of this tension is engendered in compensation cases by the many physicians involved.⁴¹

Each physical examination raises hopes. If those hopes are dashed, the patient feels helpless, and that creates anger. If it is turned inwards it becomes depression.⁴²

The problem can begin with a vagueness in the reports of attending physicians, a vagueness which may itself reflect the influence of some workers' compensation systems.

They [attending physicians] avoid a positive diagnosis for fear of controversy with the WCB. Sometimes they avoid a negative diagnosis, also to avoid controversy. They tend to refer to specialists to avoid the problem.⁴³

If more medical referrals are perceived by the patient as reflecting a suspicion about his honesty, that can obviously be a further cause of resentment and anxiety. In some cases, there are also fears of harm from the repeated examinations.

What really worries me is all those x-rays. I have had far too many x-rays. Every doctor I saw wanted more x-rays.⁴⁴

Claiming compensation can easily double or triple the number of physicians by whom a patient is examined. Apart from being damaging in

⁴⁰ D.H. Naftulin, *The Psychological Effects of Litigation on the Industrially Injured Patient* (1970), 39 *Industrial Medicine and Surgery* 167, at p. 168. For an example of repeated medical examinations leading to a "diagnosis" of functional overlay, see the Report of the Committee of Enquiry into the Victorian Workers' Compensation System (1984, Melbourne), para. 8.4.

⁴¹ Keiser, *op. cit.*, footnote 13, p. 147.

⁴² Interview with psychiatrist.

⁴³ Interview with physician specializing in occupational health.

⁴⁴ Comments of a workers' compensation claimant reported in H. Casey *et al.*, *Like It or Lump It* (1984, Federated Liquor and Allied Industries Employees Union, Melbourne), p. 11.

itself, successive medical examinations can, in workers' compensation and other insurance cases, result in periodic payments being stopped and re-commenced, or otherwise interrupted. This could be because the successive examinations swing the balance of medical opinion on the case, or more likely, just because arrangements for the examinations increase the activity on the claim and the probability of the file being "missing" when payments are due. Payment interruptions are another prime cause of increased anxiety.

If a patient claims successively under several systems, repeated medical examinations can become overwhelming.

Referral to a psychiatrist is sometimes seen to offer hope, but the timing of this involves a dilemma. If the referral is suggested at an early stage, the patient is likely to react with resentment. He may feel that he is being accused or suspected of something sinister, ranging from lunacy to dishonesty. Alternatively, given the perceived omnipotence of the medical profession, and given that the attending physician cannot arrive at an organic diagnosis of a condition that the patient believes to be organic, it may seem to the patient logical to infer that the attending physician is incompetent, or motivated by some adverse interest. Moreover, a patient may be apprehensive that his future employment opportunities will be jeopardized if he is labelled as one who "saw a psychiatrist".⁴⁵ At the least, application of the psychiatric label to a patient can have negative implications for the way other people perceive him, and for his own self-esteem.⁴⁶ Thus early suggestion of referral to a psychiatrist can add to a patient's stress, and for this reason, as well as the risk of patient refusal, it tends to be avoided.

The alternative of more examinations and testing for an organic cause avoids these problems, but it creates others. As a minimum, it may add to the conviction of the patient that there is something organically wrong with him.

. . . [the] failure to recognize and treat the emotional sequelae of accidents in the early stages following injury is unfortunate. Each additional unnecessary physical examination inflicts more damage to the emotional well-being of the patient . . .⁴⁷

A common lament of psychiatrists is that they receive this category of patients only when it is too late for effective treatment.

⁴⁵ There is cause for concern that medical information of this type is leaked to security firms, and that it becomes available to potential employers. See, *e.g.*, Report of the Royal Commission of Inquiry into the Confidentiality of Health Information (1980, Ontario), vol. 1, pp. 166-493.

⁴⁶ See, *e.g.*, B. Link, *Mental Patient Status, Work, and Income: An Examination of the Effects of a Psychiatric Label* (1982), 47 *American Sociological Rev.* 202.

⁴⁷ Keiser, *op. cit.*, footnote 13, p. 72.

F. Delay

The most damaging effect of legal systems on recovery from disablement is probably delay in the adjudication or settlement of claims. In interviews with rehabilitation personnel and others engaged in treatment, delay was the feature of legal systems most consistently mentioned at their initiative as impeding the recovery of their patients.

In workers' compensation systems in Canada, the vast majority of claims are paid quickly, with the first cheque issuing well under a month from the date of injury. However, there appears to be a substantial correlation between the minority of claims that involve delay and those that appear to involve psychological problems. With tort liability, there is no volume of claims that are paid quickly. Claims for minor injuries take months before settlement or trial, and claims for serious injuries usually take years.⁴⁸

Delay has many damaging impacts. If intermediate income is inadequate, delay can cause financial distress, particularly if it involves, as it does in some cases, the loss of household assets or the humiliation of going on welfare. Financial distress can be a major cause of anxiety. Even when intermediate income is adequate, delay in the settlement or adjudication of a claim can impede budgetary planning, which can be an essential part of rehabilitation planning. With tort claims in particular, even a patient who is told that he has a good case may find it hard to feel secure and plan for his future while his lawyer cannot tell him how much he will receive, when he will receive it, or even guarantee that he will receive anything at all.

Again, delay can increase the number of medical examinations required, which in some cases may increase the number of physicians involved, with consequential increases in psychological harm. Delays in adjudication can also delay the commencement of rehabilitation, particularly in workers' compensation where eligibility for the rehabilitation services of the boards usually depends upon eligibility for compensation. Moreover, delay in the commencement of rehabilitation does not merely delay recovery from the disability. It can have a critical and negative influence on the permanent outcome, particularly in bad back cases.⁴⁹

Delay, particularly if accompanied by successive medical examinations, can also induce suspicion in the mind of a claimant that he is not being believed, and hence can induce a perceived need to be more demonstrative in the portrayal of symptoms. While the resulting exaggeration might be attributed to monetary gain, it could more constructively be

⁴⁸ See, e.g., D. Harris *et al.*, *Compensation and Support for Illness and Injury* (1984), pp. 105-109.

⁴⁹ See, e.g., A. Jarvikoski *et al.*, *Early Rehabilitation at the Workplace* (1980), Monograph No. 6, World Rehabilitation Fund, New York, p. 6.

attributed to those features of system design that have caused the delay. Often these are the need to establish etiology, and in tort claims, the additional need to establish fault and the quantum of damages.

The waiting period can also be a period of conditioning. If a delay in adjudication leads to delay in rehabilitation, the result can be to extend the submissive sick role to which the patient has already become accustomed in hospital, and to delay the transition back to initiative, independence, and assertion.

Even when rehabilitation has commenced independently of compensation, delay in adjudication has a negative influence. The rehabilitation personnel are encouraging their patient to look forward, to forget the accident, to focus on residual abilities and potential achievements. Meanwhile, if there is a tort claim, the plaintiff's lawyer may be preparing for discovery or trial by encouraging his client to look backwards, to remember the horror of the accident, to focus on his residual disability and to catalogue his frustrations.

In this connection, it has been recommended in a handbook of basic trial advocacy that the client should keep a daily diary of every way in which the injuries have affected his life, including, how he gets in and out of bed, takes a bath, is subject to nervousness *etc.* It recommends vivid descriptions of the pain *etc.*: “. . . start at your head and, in detail, go down through all parts of your body . . .”.⁵⁰ While this advice may well be justified in terms of the tort system, it is bound to be a negative influence on rehabilitation.

G. Decentralization

In workers' compensation, a major cause of delay, misunderstandings and consequential anxieties has been the centralization of claims administration, adjudication and payment. Historically, these functions for each province were concentrated in one head office. The result was predictable. Evidence and argument are received second-hand, and claimants outside the head office city have the constant frustration of being able to communicate face to face only with people who have no authority.

A major factor is whether the claimant is able to talk to someone perceived as being able to resolve the problem. Not understanding the system is a big factor, and the distance involved in dealing with Toronto has a big impact. . . . workers' compensation is more stressful if there is a long wait. There is also the impersonal dealing with Toronto.⁵¹

Fortunately, this problem has been recognized, and there has been a movement⁵² in the last decade to decentralization.

⁵⁰ R.M. Dudnik *et al.*, *Anatomy of a Personal Injury Law Suit* (1968), p. 20.

⁵¹ Interview with a social worker at a regional rehabilitation centre.

⁵² In British Columbia, Quebec, and to a lesser extent in Ontario.

H. *Adversary Process*

Most of the problems mentioned above reach their height in systems operating an adversary process. These systems maximize the delay, the multiplicity of medical examinations, the suspicion, the fear of disbelief and the pressures to exaggerate. Moreover, these systems emphasize to the patient that there are people who may be working against the patient's interest. Perhaps the worst form of this is the surveillance (including photographing) of claimants, which is commonly undertaken by insurance companies in some jurisdictions.⁵³

Lawyers mitigate some of the problems in many jurisdictions by using agreed medical reports, or the defence accepts the medical reports of the plaintiff. Where this does not happen, however, duplicate medical examinations and conflicting medical opinions can increase the confusion and consequential anxiety for the patient.

Subjecting the victim to physical examination by the "other side" has been found to increase his anxiety about recovery, encourage him to delay physical and vocational rehabilitation, and create an incentive to exaggerate his symptoms.⁵⁴

Again, "playing down the gravity of a disability can aggravate people".⁵⁵ Moreover:

An interminable legal contest often results with the defense hard at work minimizing and deprecating the symptoms, and the plaintiff-patient repeatedly documenting a persistent disability. Such prolonged legal sparring, which often involves an attack on the patient's validity, may serve to create a more firmly fixed symptom complex than would occur in a nonadversary situation.⁵⁶

Similarly, the law reports include cases where the evidence shows the plaintiff to be suffering from a hysteria due partly to the prolonged litigation,⁵⁷ and "the files of every psychiatrist contain case histories showing that prolonged exposure to this atmosphere of combat is detrimental to the patient".⁵⁸ Indeed, it has been estimated that "easily half of the psychiatric disability ultimately seen by the defense psychiatrist is the product of the legal system".⁵⁹

⁵³ For example, in Australia.

⁵⁴ Brief by the United Steelworkers of America to the Royal Commission on the Confidentiality of Health Records (April 1978, Ontario), p. 3.

⁵⁵ Per a social worker at a regional rehabilitation centre.

⁵⁶ Finneson, *op. cit.*, footnote 29, p. 190.

⁵⁷ See, e.g., *Williams v. Jones Balers* (1964), reported in D.A. Kemp and M.S. Kemp, *The Quantum of Damages, Volume One: Personal Injury Claims* (3rd ed., 1967), p. 653.

⁵⁸ Keiser, *op. cit.*, footnote 13, p. 87. For some further comments on the negative impact of the adversary system on chronic pain syndrome, see Miller and Fellner, *loc. cit.*, footnote 31.

⁵⁹ R.R. Parlour *et al.*, *The Role of the Defense Psychiatrist in Workmen's Compensation Cases* (1981), 26 *Journal of Forensic Sciences* 535, at p. 542.

The anxieties created or aggravated by the adversary system may be associated with and perhaps partly caused by the ethical corruption that the system promotes.

... the present system is marred by temptations to dishonesty that lure into their snares a stunning percentage of drivers and victims. To the toll of physical injury is added a toll of psychological and moral injury resulting from pressures for exaggeration to improve one's case or defense and indeed for outright invention to fill its gaps or cure its weaknesses. These inducements to exaggeration and invention strike at the integrity of driver and injured alike, all too often corrupting both and leaving the latter twice a victim—injured and debased. If one is inclined to doubt the influence of these debasing factors, let him compare his own rough-and-ready estimates of the percentage of drivers who are at fault in accidents and the percentage who admit it when the question is put under oath. Of course the disparity is partly accounted for by self-deception, but only partly. And even this self-deception is an insidious undermining of integrity, not to be encouraged.⁶⁰

While the settlement of a claim can avoid the tribulations of a trial, the bargaining process can be another cause of anger and anxiety, particularly if an insurance company begins with a low offer, seen by the claimant as derisory. In cases that are not settled, anxiety about the trial itself can add to any neurosis. For example, in a recent case that came to the attention of the writer, the plaintiff informed his lawyer that he had not slept for the three weeks before the trial or for the two weeks of the trial itself.⁶¹

If the trial includes conflicting medical evidence, this can add to the problem.

Another traumatic element in the whole battle for insurance payments comes in the hearing room. Here the patient listens in fear as one doctor paints him as a mortally injured man, while another comes close to calling him a fraud.⁶²

Litigation can also impede re-employment, thus adding another cause of anxiety. Some employers, sometimes at the initiative of their insurers, decline to employ people who are engaged in litigation. This happens particularly in jurisdictions where insurance companies administer workers' compensation in an adversary system.⁶³

The adversary system generates not only suspicion, but also a suspicion of the suspicion, and this too can be an impediment to rehabilitation. For example, "a rehabilitation program often involves doing things at home, but they won't do it for fear of being watched by an insurance company".⁶⁴

⁶⁰ R.E. Keeton and J. O'Connell, *Basic Protection for the Traffic Victim* (1965), p. 3.

⁶¹ Per the plaintiff's lawyers.

⁶² Keiser, *op. cit.*, footnote 13, p. 107.

⁶³ See, e.g., C. Moore, *Compensation or Neurosis* (1982), 11 *Australian Family Physician* 871, at p. 874. Confirmed also by lawyers, union officials and employers interviewed by the writer in Australia.

⁶⁴ Per a social worker at a regional rehabilitation centre.

In tort liability, where the award of damages generally depends upon establishing fault, the adversary process can inflict psychological harm on a defendant or third party as well as on the plaintiff. For example, in one case,⁶⁵ a four year old girl ran out into the street from her home to buy ice cream. She was struck by a passing motor vehicle. She sustained physical injuries and mental impairment of such gravity that the trial judge described her as totally disabled. She sued the ice cream vendor and the driver of the car. The defendants joined the mother as a third party claiming contribution for her alleged negligence in failing to take care of her child.

In this situation, any positive contribution of the legal system to the emotional rehabilitation of the family would surely be one that helps the mother to overcome her guilt feelings, not one that entrenches and expands them. One can hardly think of anything more damaging to the rehabilitation of the family than a legal hassle, continuing over the next eight and one-half years, which included an issue of whether negligence on the part of the child's mother was a contributing cause of her disabilities.

1. *Lawyers*

Consulting a lawyer does not usually appear to have great significance in the development of a disability. At least a review of the literature⁶⁶ and the enquiries made by the writer did not reveal evidence to warrant any generalization that consulting lawyers makes personal injury claimants feel better or worse.

The response of a lawyer can, however, be very significant in some cases. For example, some lawyers are conscious of rehabilitation goals, show concern for the total rehabilitation of the client, and try to conduct a tort claim in the most constructive or least damaging manner in that context. In particular, if rehabilitation requires expensive equipment, some lawyers may negotiate with a liability insurer for that equipment to be provided immediately without settlement or release of the claim. Conversely, if a lawyer appears to be interested in the client only as a source of income, showing more concern for his time records than for the rehabilitation of the client, that may add to the client's stress.⁶⁷

Given that legal fees tend to be proportionate to the measure of damages, and given that both tend to be inversely proportionate to success in the clinical and vocational recovery of a claimant, there is obviously some potential for a conflict of interest. There are also complaints

⁶⁵ *Arnold v. Teno*, [1978] 2 S.C.R. 287. The facts are more fully stated in *Teno v. Arnold* (1974), 55 D.L.R. (3d) 57, 7 O.R. (2d) 276 (Ont. H.C.).

⁶⁶ See, e.g., C.J. Peck *et al.*, *The Effect of the Pendency of Claims for Compensation Upon Behavior Indicative of Pain* (1978), 53 Washington Law Rev. 251.

⁶⁷ See, e.g., Keiser, *op. cit.*, footnote 13, p. 85.

from rehabilitation personnel that lawyers keep going back and concentrating on the negative, and that clients sometimes receive the impression that getting better is not going to help their claims. For example: "Lawyers do not generally overtly discourage clients, but they are not anxious for them to be outstanding."⁶⁸

With regard to the influence of lawyers on a return to work pending the outcome of a claim, cases were discovered in the course of this research in which lawyers had encouraged their clients to return to work and others in which clients reported having been discouraged by their lawyers; but there is no evidence known to the writer to warrant any generalization. Many and perhaps most lawyers see returning to work as a matter for advice from the medical profession.

Perhaps the most common complaint about lawyers among personal injury claimants is not keeping the client informed, and not answering phone calls. Often these clients are already anxious, and any lack of reply from a lawyer can be very distressing.⁶⁹

III. Benefit Structures

Benefit structures are generally established primarily by reference to criteria other than their therapeutic impact. Nevertheless, it may be helpful to summarize here the therapeutic significance of some of the choices.

A. Lump Sums

The use of lump sums as damages in the tort system contributes to some of the problems described above; such as delay in the resolution of a claim, multiplicity of medical examinations, and anxieties about the amount. Sometimes lump sum compensation may also delay rehabilitation, including a return to employment. There is anecdotal evidence⁷⁰ that waiting for a lump sum settlement is sometimes a disincentive to recovery, though quantitative studies do not indicate that this is widespread, and some assertions of a widespread impact on clinical recovery are extravagant.⁷¹

⁶⁸ Per a social worker at a specialized rehabilitation hospital.

⁶⁹ See, e.g., T.L. Cory, *Clients' Needs in Facing Stress Often Neglected* (1984), 11 National No. 9 (Canadian Bar Foundation), p. 36.

⁷⁰ Particularly from interviews with physiotherapists. See also M.W. Eaton, *Obstacles to the Vocational Rehabilitation of Individuals Receiving Workers' Compensation* (1979), 45 *Journal of Rehabilitation* 59, at p. 61. It has been alleged in particular that lump sums delay rehabilitation for "invisible injuries"; Report of the Tripartite Committee on the Rehabilitation and Compensation of Persons Injured at Work (1980, South Australia), p. 27.

⁷¹ E.g.: "After all, if one is partially incapacitated, and a Common Law claim is one's only asset and security for the future, only a born fool would burst himself to recover before obtaining his verdict."; John Ellard, *Doctors, Injury and Compensation: Some Elementary Considerations* (1982), 16 *Australian and New Zealand Journal of*

Lump sums provide the maximum incentive to rehabilitation after the lump sum has been paid, but it is only in a tiny minority of cases that this can be significant. In the vast majority, rehabilitation has been completed long before the lump sum is paid.⁷² When that is not so, the patient has often become so entrenched in his ways during the long wait for the lump sum that rehabilitation is no longer viable. Assertions that the award of a lump sum will cure psychological disorders are generally against the weight of the evidence.⁷³

On a tort claim, part of the lump sum is for pain and suffering, and this can be another negative influence on rehabilitation. In particular, the evidence required to demonstrate the pain and suffering (for example, how he wept on admission for physiotherapy) can be damaging to the pride and self-respect that could support the adjustment of the patient to ongoing life with the disability.

Moreover, it is common in the negotiation of tort claims, except in very severe cases, to refer to time off work as a rough indicator of the extent of pain and suffering. Thus a claimant who returns to work promptly has more to lose than the damages for loss of earnings. For this reason, tort liability creates an incentive to prolong the absence from work that is not present in workers' compensation.⁷⁴

These negative consequences do not flow from the principle of compensation for pain and suffering; they result from the way in which it is measured. If it were measured by reference to the degree of physical impairment, using a schedule of physical impairments as a guide, and without evidence of actual pain and suffering in the particular case, most of these problems could be avoided, or at least their significance could be reduced.⁷⁵

B. *Periodic Payments*

Many problems of lump sum compensation can be avoided by the use of periodic payments. If these take the form of a fixed pension, indexed for inflation, there is the maximum incentive for clinical recovery and vocational rehabilitation.⁷⁶

Psychiatry 260, at p. 261. The reality is that the overwhelming majority of tort claimants recover and return to work or other pre-accident activity long before obtaining a settlement or verdict.

⁷² See, e.g., T.G. Ison, *The Forensic Lottery* (1967), p. 25.

⁷³ See *supra*, footnote 34.

⁷⁴ See also J. O'Connell, *A Proposal to Abolish Defendants' Payment for Pain and Suffering in Return for Payment of Claimants' Attorneys' Fees*, [1981] *University of Illinois Law Rev.* 333, at p. 341.

⁷⁵ See, e.g., T.G. Ison, *Accident Compensation: A Commentary on the New Zealand Scheme* (1980), p. 67.

⁷⁶ See, e.g., C. Safilios-Rothschild, *The Sociology and Social Psychology of Dis-*

In workers' compensation in Canada there has, unfortunately, been a movement in recent years to abandon fixed pensions and revert to the actual loss of earnings method of compensating for permanent disability. Under this method, periodic payments may be varied annually according to the estimated loss of actual earnings resulting from the disability. It is difficult to think of any method of benefit calculation more likely to perpetuate anxiety.⁷⁷ A claimant with a moderate to severe disability may be confident that as long as he remains unemployed his compensation benefits will continue. He may be apprehensive, however, that if he returns to work and then finds that he cannot cope, or if he should lose his job and be unable to find another in the open labour market, his incapacity for work would, at that stage, be attributed to factors other than his compensable disability.⁷⁸

These fears are probably at their greatest in etiologically-based systems, but they are also found in connection with disability insurance.

People [receiving benefits under a policy of disability insurance] have real fears about going back to work because if they attempt it and find they can't compete, they are worried that benefits may not be reinstated.⁷⁹

The fear is that subsequent unemployment may be attributed to economic factors, or to a subsequent disability arising outside the period of the coverage. A related problem is that policies of disability insurance do not generally pay periodical payments for partial disability. Hence there is a disincentive to undertake part-time work in cases where this might be possible, and where it might be a therapeutic benefit to the patient.⁸⁰ The same phenomenon has been observed in connection with social security administration in the United Kingdom, where periodic payments are not paid for partial disability.⁸¹

The influence of benefit levels on incentives to return to work is traditionally a controversial matter. There is a strong conviction among employers' organizations and employers' representatives that rates of compensation equivalent to one hundred per cent of lost earnings create a disincentive to return to work. While the evidence in support of this view is equivocal and controversial, it is probably more valid in relation to

ability and Rehabilitation (1970), p. 35; A. Fulkerson, Vocational Rehabilitation in the Workers' Compensation System (1980), 33 Arkansas Law Rev. 723, at p. 739.

⁷⁷ For further discussion, see T.G. Ison, The Calculation of Periodic Payments for Permanent Disability (1985), 22 Osgoode Hall L.J. 735.

⁷⁸ Examples of this fear have been found by the writer, but not enough for any quantitative estimate.

⁷⁹ Per a caseworker at an organization of disabled people.

⁸⁰ This emerged from interviews at places of medical treatment.

⁸¹ Harris, *op. cit.*, footnote 48, p. 13.

minor transitory disabilities than it is in relation to more severe and prolonged disabilities.⁸²

Conversely, a substantial reduction from normal earnings can obviously be a cause of financial anxiety and despair, particularly among families at the lower levels of earnings where there is little or no discretionary income. Probably the optimum compromise can be reached at a benefit level of about ninety per cent of projected earnings loss.

C. *Welfare*

While the welfare system was intended to be a safety net for those in need, going on welfare is notoriously a cause of additional stress, particularly for disabled people who believe themselves to be eligible for workers' compensation or other insurance benefits. The means test, and in some jurisdictions the degradation involved in visiting the office at which benefits are obtained,⁸³ are additional causes of stress.

Moreover, some welfare authorities have fixed budgets for supplementary aid, with the result that rehabilitation equipment may be denied for budgeting reasons. Apart from causing emotional distress, this can be a direct cause of physical health problems, such as pressure sores or other types of disease. Where extra benefits are provided through supplementary aid, they may be terminated in the event of return to work. This feature too can be counter-productive in its influence on rehabilitation.

These negative influences of the welfare system can be seen as a by-product of the delays and the limitations in coverage that characterize the etiologically-based systems.

IV. *Rehabilitation Structures*

A. *Clinical Rehabilitation*

A tort claim may influence the progress of clinical rehabilitation but it does not usually produce any change in the institutional structure. Claimants receive treatment in the same way and at the same places as those without tort claims. A workers' compensation claim, however, can make a difference to the institutional structure of rehabilitation, particularly in jurisdictions where workers' compensation boards operate their own rehabilitation clinics.⁸⁴

⁸² This is partly because workers' compensation systems rarely compensate for loss of fringe benefits, and such losses are more likely in cases of more severe or prolonged disability.

⁸³ For example, at least some of the offices administering supplementary benefits in the U.K.

⁸⁴ In Canada, these are British Columbia, Alberta, Ontario, and New Brunswick.

The provision of clinical rehabilitation by workers' compensation boards has several advantages. First, because rehabilitation is perceived as a way of saving vast sums of money in compensation funds, it is also perceived as something on which money should be spent. Perhaps for this reason, the board clinics sometimes have equipment and other facilities beyond those that are available elsewhere. Some of the clinics also have extensive industrial workshops. Thus comprehensive programs of physical therapy, counselling, job assessment and work practice can be provided that would be less likely to come about without the linkage of clinical rehabilitation with the compensation system.

Secondly, disabled workers are commonly classified in compensation systems and by employers in arbitrary and extreme ways, such as "unfit for work" or "fit for work", though often with an intermediate classification, such as "fit for light work". These classifications are intended to meet an administrative need, but they can be counter-productive in relation to a worker who wants to return to work and is apprehensive about his capacity to cope. These classifications would not generally be used by, for example, physicians, business executives, or scholars in relation to themselves. When recovering from a disability, they can ease their way back to work, doing a little at first, and then building up the amount as they feel better. Similarly a disabled industrial worker may like to feel his way back to full employment, perhaps beginning with a little, working at his own speed, being able to rest or quit at a time of his own choice, and without being subject to a foreman who has expectations of a predetermined level of performance. This graduated return to work is, however, often unattainable in an industrial setting. This is one of the problems that board clinics, if they work well, can help to overcome.

Thirdly, the administration of clinical rehabilitation by a workers' compensation board might create a sense of urgency that is crucial to the momentum of rehabilitation. In bad back cases in particular, there appears to be a consensus among rehabilitation personnel that the psychological dimensions of the disablement generally become entrenched if the patient is left without effective diagnostic and treatment services for about six months.

These advantages must be balanced, however, against the negative influences that board clinics may have on the recovery of patients. First, admission to a board clinic can increase the number of doctors by whom a patient is examined,⁸⁵ and can be disorienting in other ways. For example, claims adjudication and rehabilitation counselling may be in the hands of different people, and if the patient normally lives beyond

⁸⁵ See heading II E above. See also B.H.G. Curry, *Workmen's Compensation Board Hospital and Rehabilitation Clinic*, [1973] *Medical Trial Technique Quarterly* 121, at p. 131.

daily travelling distance of the clinic, he may be removed from the support of family life. The disorientation and multiplication of medical examinations can be aggravated if the patient has a non-compensable disability in addition to the compensable disability, and if the non-compensable disability is being treated concurrently elsewhere.

The administration of a clinical facility by a workers' compensation board can also increase anxiety in other ways. Patients sometimes assume that success in treatment will be measured by the termination of compensation payments, and that consequently incentives or pressures might exist for clinic staff to be unduly hasty in classifying patients as recovered. Where this fear exists, patients may react by striving to avoid or deny partial success in therapy, or otherwise by striving to prove their disabilities. Again, the connection with the compensation system may induce a patient to fear that if he is unable to progress to the satisfaction of the treating doctor, he may be labelled a malingerer.

Other problems, too, can arise if this structure is perceived as a form of benefit control. Obviously any reduction in candour by patients can aggravate the difficulties of diagnosis and the prescription of treatment. There may also be a risk of alternative and more imaginative forms of rehabilitation, which may have greater potential in some cases, being overlooked. For example in some cases, where a patient is already too institutionalized, some form of voluntary work in the local community could be preferable to the clinical setting as a step towards employment.

Another limitation is that because the board clinics have a captive clientele, the quality of their output is not monitored by market movements. They are relatively immune from the market pressures that might compel a sensitivity to client satisfaction, or client perceptions of the quality of the treatment. This may help to explain the paramilitary atmosphere that has prevailed in some periods at some of the compensation board clinics. To some extent, however, the political process serves as a substitute for the lack of market mechanisms for quality control, and even market mechanisms operate to some extent. For example, it is fairly common nowadays for a board to accommodate any preference that a patient may have for treatment elsewhere.

Without allocating enormous resources to an extensive inquiry, it would be impossible to reach any overall conclusion on whether the administration of rehabilitation clinics by workers' compensation boards is desirable, or whether such clinics should be separated entirely from compensation systems. No doubt too the advantages and disadvantages of this structure vary with time and place. For what it is worth, however, the hunch of the writer is that, on the whole, this structure probably does more good than harm.

It is also interesting to note that whatever therapeutic damage this structure might do could to a large extent be avoided by the abolition of

etiologically-based compensation systems, and their replacement by a comprehensive plan. A consequence of having a rehabilitation clinic administered by a workers' compensation board is that patients are classified etiologically for the purpose of clinical treatment. This contrasts dramatically with the classifications that would make the greatest contribution to overall success in rehabilitation. For example, diagnostic classifications may sometimes be useful to facilitate specialization and economies of scale in treatment. Geographical classifications and regional rehabilitation facilities can have advantages in preserving home contacts. Perhaps age classifications might have some use. Occupational classifications may be useful on the theory that those returning to manual labour require more intensive therapy than those returning to sedentary positions. Etiology, however, is generally irrelevant to clinical rehabilitation needs. Thus if the total clientele of clinical rehabilitation facilities is divided etiologically, there is a proportionate decrease in the use of classifications which could contribute more to the success of rehabilitation for disabled people as a whole.

A comprehensive plan of compensation for disablement, under which eligibility for benefits does not depend upon etiology, could preserve the benefit of connecting clinical rehabilitation with compensation while at the same time not impairing the use of other classifications that would maximize the overall success of clinical rehabilitation.

B. Social Rehabilitation

This term refers to assistance to a disabled person in readjustment to employment, family, recreational and community life. As with clinical rehabilitation, the administration of rehabilitation services by a workers' compensation board has substantial advantages compared with a separate structure. In particular, it tends to create a sense of urgency that is crucial if damaging delays are to be avoided. Again, having the claims adjudicator and the rehabilitation consultant working under common direction for the same organization can promote consistency in their communications. This can minimize the risk of anxieties being created by an adjudicator and a rehabilitation consultant having different expectations of the patient.

There are, however, significant problems with this structure. Here again, many and perhaps most of these result not from the administration of rehabilitation by a compensation authority, but from the administration of rehabilitation services in conjunction with a compensation system that is etiologically based.

Perhaps the major problem is timing. While the connection with the compensation system probably results in speedier rehabilitation in most cases, it can create delays in some. If there is a delay in adjudication, perhaps to determine etiology, there may be a consequential delay in the commencement of rehabilitation until it has been decided whether the

disability is compensable. A similar problem arises outside the workers' compensation context. For example, in relation to disability insurance, cases arise in which the insurer delays the provision of equipment to see what government services will provide, and *vice versa*.

The converse problem may arise towards the end of a claim. The recovery of a patient and the termination of compensation benefits, or the assessment of a pension, do not as a matter of law terminate eligibility for rehabilitation services,⁸⁶ but they often have that effect in practice.

Another concern is that this structure may restrict a patient's ordinary freedom of choice, sometimes to the extent of becoming a serious intrusion on civil liberties. This risk is at its height when periodic payments are measured by reference to actual loss of earnings. In connection with the administration of rehabilitation services by welfare authorities, it has been argued that:

Invariably, the tendency will be for dispensers to seek or assume greater control over recipients. The greater the control, the greater the ability to minimize costs. But the greater the control exercised by dispensers, the less will be the freedom enjoyed by recipients.⁸⁷

In its worst form, this control can make rehabilitation services a euphemism for benefit control by punitive surveillance.

Where rehabilitation services departments of workers' compensation boards operate properly, the rehabilitation consultants identify suitable jobs and assist the claimants in obtaining them. What has happened at some boards, however, is that claimants are required to make a daily job search as a condition of continuing eligibility for benefits, and to report to the board a minimum number of job solicitations made in each time period. A claimant must do this, notwithstanding that the board, through the use of its own resources and experience, has been unable to identify any suitable employment for which he might apply. It is hard to conceive of anything more debilitating, or more counter-productive in relation to genuine rehabilitation, than to require a client to subject himself to a process of constant rejection.

Another problem with the structure is that vocational rehabilitation is sometimes pursued to the exclusion of other social goals.⁸⁸ Indeed, the rehabilitation services departments of some workers' compensation boards are actually named vocational rehabilitation departments. Moreover, there is a propensity for return to the pre-injury employment to be perceived automatically as the primary goal. Typically, the priorities are listed as:

⁸⁶ T.G. Ison, *Workers' Compensation in Canada* (1983), para. 277.

⁸⁷ Canadian Civil Liberties Association, *Civil Liberties and the Administration of Public Welfare* (1970), p. 1. See also Comment, *A Model Negative Income Tax Statute* (1978), 78 *Yale Law Journal* 269, at p. 282.

⁸⁸ See, e.g., E.M. Ross, *Rehabilitation and Workmen's Compensation* (1975), 23 *Occupational Health Nursing* 14, at p. 15.

- (1) return to the pre-injury occupation with the pre-injury employer;
- (2) return to some other suitable employment with the pre-injury employer;
- (3) placement in some other suitable employment.⁸⁹

This approach tends to exclude other dimensions of social rehabilitation (such as recreational activity or domestic adjustment) either as independent goals, or as a prelude to employment. This approach may also overlook the potential risk of the pre-injury employment as a cause of further injury, and whether some alternative employment might not be healthier for the claimant in the long run. Again:

Many workers would like to embark on a career change following injury for reasons that may not be understood by or even explained to doctors or rehabilitation consultants, but the rehabilitation process tends to expect their return to the previous occupation.⁹⁰

Another influence of the compensation system on re-employment is experience rating. It can create an incentive for an employer to assist in getting a disabled worker back to work, but it can also increase the anxieties of a disabled worker by creating suspicions. If the employer's motivation is the reduction of compensation costs (which would be short-term), the re-employment offered to the worker might not be secure and healthy in the long run.

A more severe problem arises if rehabilitation is associated with a compensation system that does not pay benefits for partial disability. In this connection, there has been a trend in recent years for disability insurers to seek involvement in rehabilitation programs, even to the extent of arguing that they should be part of "the rehabilitation team". Any such role creates obvious conflicts of interest, and the claim to such a role may well be a cause of anxiety to a patient, particularly if his attending physician appears to acquiesce. Where a policy of disability insurance pays ongoing benefits only for total disability, a patient may suspect that the interest of the insurer in rehabilitation is simply to demonstrate that the disability is less than total. Hence if a proposed rehabilitation program is likely to result in some employment income, but of modest amount or uncertain continuity, the patient might be tempted to resist.

Conclusions

Present systems of compensation for disablement do not appear to inflict therapeutic damage on any broad scale. Indeed, systems under which benefits generally commence very quickly, such as the Canadian systems

⁸⁹ See, e.g., Annual Report of the Workers' Compensation Board for the Yukon for 1980, p. 4.

⁹⁰ C.M. Brodsky, *Compensation Illness as a Retirement Channel* (1971), 19 *Journal of the American Geriatrics Society* 51.

of workers' compensation, have a broad beneficial influence in relieving clients from financial anxiety. Nevertheless, compensation systems do produce significant therapeutic damage in some cases. The therapeutic significance of compensation structures is, therefore, sufficiently important that it should be considered in any revisions of system design. This consideration is most likely to occur when a system is revised through careful contemplation by people who can see the impact of the options on the system as a whole, and on interaction with other systems. It is least likely to occur when a system is revised by *ad hoc* responses to lobbying pressures, guided primarily by the political pragmatism of the moment.

While a switch from etiologically-based systems to a universal and comprehensive system of compensation for disablement is desirable for other reasons,⁹¹ it would also have therapeutic advantages in:

- (1) eliminating a distorting influence on medical opinions relating to diagnosis and etiology, thereby improving accuracy and the prescription of treatment;
- (2) reducing the incidence of delay in the payment of claims, particularly by eliminating the delay that occurs in tort claims, thereby reducing anxiety and disincentives to clinical or vocational rehabilitation;
- (3) reducing psychological impairment by reducing the number of medical examinations required and the number of physicians involved in a case;
- (4) reducing the incidence of physical intrusion required by some diagnostic techniques;
- (5) improving communication between claims adjudicators, rehabilitation consultants and claimants by facilitating greater decentralization;
- (6) permitting more useful classifications to be used in the establishment of clinical rehabilitation facilities while at the same time preserving the advantages of attaching those facilities to the compensation system.

The incidence of monetary gain is readily and perhaps grossly overestimated. Any medical opinion containing a diagnosis of monetary gain, secondary gain, compensation neurosis or functional overlay should be subjected to cross-examination, particularly to discover what symptoms supported the diagnosis. Any such "diagnosis" reached only by exclusion should be rejected.

⁹¹ See, e.g., T.G. Ison, Human Disability and Personal Income, in L. Klar (ed.), *Studies in Canadian Tort Law* (1977), c. 15; R. Lewis, *Tort and Social Security: The Importance Attached to the Cause of Disability with Special Reference to the Industrial Injuries Scheme* (1980), 43 *Modern Law Rev.* 514.

To minimize the psychological dimensions of a disability, as well as for other reasons, primary adjudication must be perceived as a thoughtful and crucial role. Except for minor transitory disabilities, primary adjudication is not a role for clerical grade personnel.

The response to a doubtful claim must be one of prompt and sensitive investigation. Any practice of denying doubtful claims to see if a claimant appeals is likely to result in therapeutic damage as well as injustice.

Any compensation payable for intangibles such as pain and suffering, and loss of amenities of life, could be calculated by the degree of physical impairment, using a schedule as a guide, rather than by an open-ended intuitive judgment. This would reduce therapeutic damage as well as improving fairness and efficiency.

Any program of abuse control should include the abuse of claimants as well as abuse by claimants, and any program for the control of abuse by claimants should be carefully targeted. It can include punishment for those guilty of fraud, but it should not be so indiscriminate that every claimant is treated with suspicion.

A compensation system that pays only for total disability is less conducive to rehabilitation than one that pays also for partial disability.

The adversary model of adjudication has serious disadvantages when used in relation to compensation for human disablement and death.

In workers' compensation, experience rating is a cause of therapeutic damage.