

THE RAINMAKER REVISITED: PUNITIVE AND AGGRAVATED DAMAGES IN THE REAL WORLD OF DISABILITY INSURANCE

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In the recent case of Whiten v. Pilot Insurance Co., punitive damages for bad faith against a first-party insurer were awarded in an amount far exceeding "traditional" levels. At the same time the law of aggravated damages, as applied to disability insurers, may be changing in a way that allows for the imposition of such damages even where the insurer has acted reasonably and in good faith. This paper examines, from the point of view of the disability insurer, the developing law of punitive and aggravated damages.

Dans le jugement récent de Whiten c. Pilot Insurance Co., la Cour a conclu que l'assureur avait agi de mauvaise foi et l'a condamné à payer des dommages punitifs excédant les niveaux traditionnels. De plus, la jurisprudence quant aux dommages moraux dans le domaine de l'assurance-invalidité évolue de sorte que de tels dommages peuvent être accordés même dans les cas où l'assureur a agi comme assureur raisonnable et de bonne foi. Le présent document traite de l'évolution de la loi des dommages punitifs et moraux du point de vue de l'assureur dans ce domaine.

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I. Introduction

In his legal thriller *The Rainmaker*, John Grisham tells the tale of a struggling young lawyer, Rudy Baylor, litigating a claim for medical insurance benefits on behalf of a terminally ill client against big-bad insurer Great Benefit Life Insurance Company. It turns out, that Great Benefit has a policy of denying all

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claims until the claimant gets a lawyer, at which point it will enter into settlement discussions. Mr. Baylor's client's mother has neither the resources nor the wherewithal to get a "real" lawyer and so, by the time Mr. Baylor meets her, she has written seven letters on her son's behalf seeking the insurance benefits necessary to pay for the procedure which may save his life. Great Benefit, in turn, has responded to each of her letters with increasingly terse denials, with the last one reading "We now deny it for the eighth and final time. You must be stupid, stupid, stupid!" In the end, Mr. Baylor wins his case and his client is awarded punitive damages in the sum of fifty million dollars.

Any assumption that disability insurers in Canada operate on principles similar to the fictitious Great Benefit Life Insurance Company would be stupid, stupid, stupid! Punitive damages for bad faith have been awarded on only two occasions against Canadian disability insurers, and the alleged "bad faith" leading to these awards is difficult to find in the decisions. Moreover, in both cases, the amount awarded in punitive damages was \$7,500.00. However, the case of *Whiten v. Pilot Insurance Co.*¹ has put the fear of judicial retribution in disability insurers' hearts throughout Canada. Although not a disability insurance case, *Whiten* represents the "high-water" mark in Canada in terms of a first-party insurer being ordered to pay punitive damages for bad faith to its insurance claimant. In that case, the Whitens' house burnt down, their insurer unjustifiably suspected arson through to the trial judgement, and the jury, in addition to awarding damages for the loss of the house and possessions, also awarded the Whitens one million dollars in punitive damages. This amount was reduced to one hundred thousand dollars by the Ontario Court of Appeal (over a strong dissent by Laskin J.A.),² but this is still a lot more than disability insurers are accustomed to and they fear that six or seven figure punitive damages awards may one day be made against them.

The first part of this paper examines the developing law of punitive damages for bad faith to see just how worried the disability insurer should be and how mouth-watering the prospect of punitive damages should appear to the insurance claimant. One thing that is clear at least, with respect to punitive damages, the disability insurer must have acted in "bad faith". Exactly what this means will be explored below. On the other hand, terms of potential awards of aggravated damages, even a disability insurer who has acted with utmost good faith cannot rest easy. The law of aggravated damages, as it appears to be developing, at least in British Columbia, is that they may flow automatically from a breach of a disability insurance contract no matter how reasonable the insurer has acted in its decision to deny benefits. This result follows from the British Columbia Court of Appeal having recently characterized disability insurance policies as "peace of mind" contracts, just like contractual vacation arrangements. The object of these contracts, the court has said, is to provide peace of mind and, when they are breached, whether in good faith or not,

¹ (1996), 132 D.L.R. (4th) 568 (Ont. Gen. Div.).

² (1999), 170 D.L.R. (4th) 280.

mental distress virtually automatically flows from the breach. This distress, according to the B.C. courts, is to be compensated by an award of aggravated damages on top of the benefits contracted for. These issues will be addressed in the second part of the paper.

II. "Traditional" Notions of Punitive and Aggravated Damages

Although the terms "punitive damages" and "aggravated damages" have occasionally been used interchangeably, the Supreme Court of Canada, in *Vorvis v. ICBC*³ clarified the distinction between them:

Punitive damages, as the name would indicate, are designed to punish. In this, they constitute an exception to the general common law rule that damages are designed to compensate the injured, not to punish the wrongdoer. Aggravated damages will frequently cover conduct which could also be the subject of punitive damages, but the role of aggravated damages remains compensatory....Aggravated damages are awarded to compensate for aggravated damage....they take account of intangible injuries and by definition will generally augment damages assessed under the general rules relating to the assessment of damages. Aggravated damages are compensatory in nature and may only be awarded for that purpose.

In clarifying that aggravated damages must be compensatory, the Supreme Court also made clear that, in a contract case, such damages could only flow from an independently actionable wrong. Thus, the court approved the following passage:

If a course of conduct by one party causes loss or injury to another, but is not actionable, that course of conduct may not be a separate head of damages in a claim in respect of an actionable wrong. Damages, to be recoverable, must flow from an actionable wrong. It is not sufficient that a course of conduct not in itself actionable, be somehow related to an actionable course of conduct.

In other words, where a plaintiff has a cause of action for breach of contract, whether or not that breach caused intangible injuries, aggravated damages will not flow from it. They will only be awarded if the party breaching the contract also committed independently actionable acts that caused the intangible injuries. More simply, in the disability insurance context, *Vorvis* stands for the proposition that the insurer will not be saddled with aggravated damages unless it has done something wrong apart from simply denying insurance benefits when they were in fact payable. Thus, according to *Vorvis*, the insurer acting reasonably in denying a claim need not worry about aggravated damages.

Vorvis is also the leading case on the type of conduct that will result in an award of punitive damages. As stated in *Vorvis*:

Moreover, punitive damages may only be awarded in respect of conduct which is of such nature as to be deserving of punishment because of its harsh, vindictive, reprehensible and malicious nature. I do not suggest that I have exhausted the

³ (1989), 58 D.L.R. (4th) 193, at 201-02.

adjectives which could describe the conduct capable of characterizing a punitive award, but in any case where such an award is made the conduct must be extreme in its nature and such that by any reasonable standard it is deserving of full condemnation and punishment.⁴

The court also said:

all authorities accept the proposition that an award of punitive damages should always receive the most careful consideration and the discretion to award them should be most cautiously exercised.⁵

Finally, the court was explicit that, in a contract case, punitive damages could only be awarded for conduct constituting an independently actionable wrong. Thus the court approved the following passage:

Punitive damages are not recoverable for breach of contract unless the conduct constituting the breach is also a tort for which punitive damages are recoverable.⁶

If *Vorvis* were the last word on the subject, the disability insurer would not need to worry too much about either aggravated or punitive damages. One would have to work very hard at being evil enough to satisfy the *Vorvis* test for punitive damages and, since even aggravated damages require, an independently actionable wrong, the reasonable insurer would not need to worry about them either.

III. *The Insurer's Duty of Good Faith*

What is an independently actionable wrong that might be committed by a disability insurer? It is generally alleged to be a breach of the insurer's duty of good faith to its insured.

There is no question that disability insurance contracts are ones of *uberrimae fidei* (utmost good faith) and that the insurer owes its insured a duty of good faith in the handling of the insured's claim. There is a corresponding duty of good faith on the insured, for instance, to tell his or her insurer the complete truth about capabilities and activity levels. The problem lies in defining the scope of the duty. In *Adams v. Confederation Life*,⁷ one of the two disability insurance cases where punitive damages were awarded, the court went on for six pages about the content of this duty before endorsing the following:

The duty of good faith is founded on the principle of *uberrima fides* which Mr. Matthews defines as 'a curious animal: arising from an indefinite source, with an undetermined content' of 'considerable flexibility and versatility.' The article is focussed on the issue of disclosure by both parties, but he does recognize that there can be other manifestations of the duty....However defined at this time, it is clear from these authorities that an insurer owes a yet undefined duty of good faith to its insured.

⁴ *Ibid.* at 208.

⁵ *Ibid.* at 206.

⁶ *Ibid.* at 207.

⁷ (1994), 25 C.C.L.I. (2d) 180 at 204 (Alta. Q.B.).

It is a duty which in certain circumstances, resembles a fiduciary duty but is always governed by fair play in every dealing.

Obviously, this description of the duty of good faith does not provide any specific guidance as to what acts of either good faith or bad faith might be. Other cases, particularly ones where aggravated and/or punitive damages have been claimed but denied by the court, are a little more helpful. First of all, it is clear that there is no bad faith on the part of the disability insurer in incorrectly assessing the evidence submitted by the insured as being insufficient to satisfy the policy test of "totally disabled". As stated in the case of *Ritch v. Sun Life*:⁸

The mere denial of continuing total disability benefits for want of satisfactory proof of continuing disability is not on its face an act of bad faith. There is no requirement on the insurer to subordinate its legitimate economic and contractual interests to those of the insured.

As put more bluntly in the case of *Eddie v. Unum Life Insurance Company of Canada*:⁹

Of course, a denial of insurance benefits by an insurer may be wrong-headed but made in good faith.

Another case, *Richardson v. Great-West Life*¹⁰ indicates the following:

Thus, while the preponderance of the evidence in this case favours the plaintiff, in my opinion the totality of the evidence falls short of being 'overwhelming' and did justify some degree of scepticism on the part of the defendant. As a result, I am unable to conclude that the plaintiff has proven the conduct of the defendant was so high-handed or tantamount to bad faith so as to justify an award of either aggravated or punitive damages.

Again, it is difficult to extract anything more than generalities from the above-discussed case-law on the duty of good faith. From the point of view of the disability insurer, it is nice to know that we do not have to subordinate our contractual interests to those of the insured, that we can be wrong-headed, and that some justified degree of scepticism about a claim may avoid aggravated or punitive damages. It is also clear that the duty of good faith owed by the disability insurer to the insured is not a fiduciary one. Even the Ontario Court of Appeal in *Whiten v. Pilot Insurance Company* agreed with this proposition as follows:

A contract of insurance between an insurer and its insured is one of utmost good faith. Although the insurer is not a fiduciary, it holds a position of power over an insured; conversely, the insured is in a vulnerable position, entirely dependant on the insurer when a loss occurs. For these reasons, in every insurance contract an insurer has an implied obligation to deal with the claims of its insureds in good faith.¹¹

In terms of defining the duty of good faith, the case-law does not get any more specific than described above. Let us now look at the cases where the court has

⁸ [1998] I.L.R., I-3574 (Ont. Gen. Div.).

⁹ (1999), 4 C.C.L.I. (3d) 223 at 233 (B.C.S.C.).

¹⁰ [1996] I.L.R., I-3376 (Alta. Gen. Div.).

¹¹ *Supra* note 2 at 291.

found that the duty has been breached. I will begin with the two cases, in the disability insurance law context, where the court has determined the breach to be serious enough to merit an award of punitive damages.

IV. *Punitive Damages*

a. *The Adams and Ferguson Decisions*

Adams v. Confederation Life

The award of punitive damages in *Adams v. Confederation Life* was very much tied to an agreement that the parties entered into which was separate from the relevant insurance policy. After total disability benefits were paid under the relevant policy for about two years, the parties, in July 1990, entered into a rehabilitation agreement, whereby the plaintiff would work 16 hours per week in the family bookstore. The plaintiff was obligated to notify Confederation Life if she could work more than the 16 hours. She was further required to submit medical support for her continuing disability every six months. Confederation Life, for its part, agreed that, among other things, as of July 1992, it could request an independent medical examination by a specialist of its choosing.

Instead of requesting the IME in July of 1992, Confederation Life commissioned surveillance of the plaintiff. The surveillance report received by Confederation Life indicated that, over the week the plaintiff was watched, she put in 43.5 hours of work. Based on this report, Confederation Life terminated the plaintiff's benefits.

As it turned out, the investigator's conclusions were not given any credibility at trial. The plaintiff produced an independent witness to testify that, on two of the days the plaintiff was allegedly seen working, she was in fact out-of-town. This witness' evidence was accepted by the court. The court found that the surveillance reports contained the "obvious error...that they equate attendance at the bookstore with hours of work." As well, it found that the surveillance, mainly conducted from vehicles parked outside the store with inadequate visibility of what was happening inside, did not meet the standard of proof that the plaintiff was actually working during the hours she claimed. In the end, with regard to punitive damages, the court said the following:

Did the actions of the insurer in this case amount to a breach of its duty of good faith under the principle of *uberrima fides*? My answer is "Yes." The decision to embark on covert surveillance without reason or cause is obvious on the facts. By this, I do not mean to be taken as saying that surveillance is an improper investigative technique for insurers to prove an unmeritorious claim. But in this case, and in these circumstances, the defendant had accepted the claim and had committed to a course of dealing under the policy which required it to deal fairly with the plaintiff. It did not. Medical certificates were provided as required under the rehabilitation agreement. The defendant had requested and received additional medical information from the attending physician. It did not exercise its right to an independent medical examination

in July 1992 as provided by this agreement. No inquiry or request was made of the plaintiff to provide any certification of hours worked. It simply launched an unwarranted and unmerited investigation without reason by its admission. It acted solely on the basis of two totally inadequate investigative reports.¹²

As indicated above, the court awarded the plaintiff \$7,500.00 in punitive damages.

It is difficult to draw conclusions from the *Adams* case that might be applicable to other cases. A great deal in the *Adams* case depended on the rehabilitation agreement which, as indicated above, the court characterized as a commitment to a "course of dealing". Since this "course of dealing" entailed specific enumerated representations and promises by each party, the court found Confederation Life to have acted in bad faith in straying from the agreed terms of that "course of dealing" and instead ordering surveillance.

Adams is certainly a precedent for punitive damages for bad faith being awardable in disability insurance cases. However, since one does not often find the type of "side-deal" that Confederation Life struck with Ms. *Adams*, the case would seem to have little precedential value.

In my opinion, it is no authority for the proposition that reliance on "flawed" surveillance should or will lead to punitive damages. There is obviously no bad faith whatsoever in relying on a surveillance report that one does not know to be flawed. Indeed, it is my submission, that the court was a little harsh in describing the equation of attendance at the bookstore with hours of work as an "obvious error". If surveillance shows an individual arriving at a place of work at 8 a.m. and leaving the place of work at 4 p.m., the most reasonable inference is that the individual worked those hours. If incorrect, as the court found in the *Adams* case, than total or partial disability may be substantiated; the insurer will have to pay the claim, in addition to interest and costs. The imposition of an additional burden of punitive or aggravated damages in these circumstances would seem to me to be unduly harsh. In any event, as indicated above, it does not appear that the punitive damages award in *Adams* was based on reliance on the "flawed surveillance", but on Confederation Life straying from a course of conduct that had been committed to.

*Ferguson v. National Life*¹³

From the point of view of the disability insurer, the award of \$7,500.00 in punitive damages in the *Ferguson* case is most puzzling. A brief review of the facts is in order.

Mr. Ferguson had a grade 10 education and was a bus driver for the Ottawa-Carleton region. He developed a stress disorder and could not cope with the problems of working on a time schedule and dealing with difficult customers.

¹² *Supra* note 7 at 204-05.

¹³ (1996), 36 C.C.L.I. (2d) 95, aff'd. (1997), 102 O.A.C. 239.

The early medical opinions, from both Mr. Ferguson's doctors and doctors retained by National Life, were optimistic about Mr. Ferguson returning to work, if not to his own job, at least to some other job. Based on these "early" opinions, and Mr. Ferguson's statements that he wanted to, and could, start his own scrap-yard business, National Life terminated benefits after the 24 month "own occupation" period.

Unfortunately, the scrap-yard business never got beyond the "idea" stage as Mr. Ferguson's condition failed to improve and the medical reports began to get pessimistic about him returning to any form of work. Based on these factors, National Life reinstated benefits and paid them for almost 3 years into the "any occupation" period.

Before the termination of benefits on September 30 1989, National Life sent Mr. Ferguson for an independent medical examination with a clinical psychologist, Dr. Crépeau. Dr. Crépeau's June 27 1989 report indicated:

Claimant clearly appears capable of returning to the labour market in a function compatible with his experience and training.

Subsequently, medical information was submitted to National Life from Mr. Ferguson's doctors which supported total disability. Finally, in December of 1995, National Life received a report from an independent psychiatrist who concluded:

Mr. Ferguson does not present symptoms of a major psychiatric illness which would prevent him from working in a job suited to his education, training and experience.

It should be noted that, throughout the relevant time period, the diagnoses attributed to Mr. Ferguson were numerous. There is mention in the case of diagnoses of anxiety/depression, reactive depression, passive aggressive personality, paranoid state with hypochondriasis and obsessive compulsive personality. The trial judge in fact agreed that, "the plaintiff's condition has undoubtedly been difficult to diagnose."¹⁴

Given the state of the evidence going into trial, with the problems, the case was difficult (with problems of diagnosis, and medical evidence on both sides). Not surprisingly, the court concluded that Mr. Ferguson was totally disabled and entitled to retroactive benefits and a declaration of entitlement until such time as the total disability ceased. However, the court went further:

....this is one of those rare cases where the defendant's conduct has been so harsh, calculated, reprehensible, malicious and extreme as to be deserving of full condemnation and punishment. In these circumstances, an award of punitive damages is justified. An appropriate award for punitive damages in this case would be \$7,500.00¹⁵

It is, impossible from a reading of the case, to find "reprehensible, malicious and extreme" conduct on the part of National Life. The court, however, cited two

¹⁴ *Ibid.* at 130.

¹⁵ *Ibid.* at 135.

alleged examples of such conduct. Firstly, in its letter to the plaintiff advising him of the independent medical examination with Dr. Crépeau, National Life indicated that their intention was to seek a "second medical opinion". This phraseology, said the court, was calculated to mislead the plaintiff into believing Dr. Crépeau was a psychiatrist rather than a psychologist. Unless the court was relying on some evidence that did not make it into the judgement to support this inference, it does not appear supportable. The mere fact that a claims examiner would use the word "medical" in referring to a doctor of psychology is not, by any stretch of the imagination, the type of reprehensible conduct that is required for punitive damages.

Secondly, the fact that Dr. Crépeau was located in Montréal, forced the plaintiff to travel from Ottawa to Montréal for the independent medical examination. The court pointed to the fact that a couple of medical reports had indicated that the plaintiff had symptoms of agoraphobia and that, given knowledge of these symptoms, National Life should have arranged the IME closer to home.

Again, the court cites no evidence that the selection of Dr. Crépeau in Montréal was done maliciously to aggravate the plaintiff's symptoms of agoraphobia. Indeed, among all the possible diagnoses the plaintiff was given, agoraphobia was never one of them. As far as can be made out from reading the case, neither the plaintiff's doctors nor those retained by National Life ever focussed on the agoraphobia and the most reasonable inference is that National Life's claims examiners were not focussing on it either when they arranged the IME with Dr. Crépeau. Only Bell J. focussed on the symptoms of agoraphobia in an attempt to justify an award of punitive damages. In my opinion, the facts relied upon by Bell J. do not meet the *Vorvis* test for punitive damages. At most, an award of aggravated damages might have been appropriate.

Nonetheless, the decision stands and its value as a precedent must be considered. Is there more that insurers can learn about the case other than they should not use the word "medical" to refer to psychologists, nor send insureds with agoraphobic symptoms out of town for their IME's? The disturbing lesson for the disability insurer is that such factors could be thought to satisfy the *Vorvis* test. I would feel much better about the case if the court had based its conclusions on some evidence (an admission, for instance) that National Life had maliciously tried to mislead the plaintiff into thinking Dr. Crépeau was a psychiatrist and had maliciously sent the plaintiff to Montreal knowing it would aggravate his symptoms. If such evidence were present, I would readily concede to the award of punitive damages. The court, rather than acting on evidence, appears to have inferred malice from conduct which, at best, seems innocuous, and, at worst, careless. It remains to be seen whether the *Ferguson* case is, like *Adams*, a bit of an aberration, or whether it represents a watering-down of the *Vorvis* requirements for punitive damages.

Interestingly, the court in *Ferguson* considered and then rejected the prospect of awarding punitive damages for National Life's termination of

benefits at the 24-month point and subsequent reinstatement. In describing this conduct, Bell J. said:

While I conclude that the defendant's conduct relating to the termination of the plaintiff's benefits was not justified and was unreasonable, the defendant did reinstate the plaintiff's benefits and did repay any lost benefits within a few months. That conduct would not warrant an award of punitive damages....¹⁶

This statement appears to indicate that a disability insurer will not be liable for punitive damages for its claims handling as long as the claim is being paid or, as long as there has only been a brief termination of benefits.

b. *Whiten v. Pilot Insurance*

As indicated above, *Whiten* is not a disability-insurance case. The facts of the case are quite simple. The Whitens' house burned down and they made a claim against Pilot Insurance, their home-insurer, for replacement of the structure, loss of contents, increased living expenses, and punitive damages. Pilot's denial of the claim, at the claims level and all the way through to judgement, was based on its suspicion that the fire was as a result of arson, that is, that the Whitens had burned down their own house. At trial, the jury awarded \$277,500.00 for loss of the home and contents and a further \$1,000,000 in punitive damages. The reasoning at the trial level constituted a good news/bad news scenario for the disability insurer.

The good news is that, by all accounts, the insurer's conduct in the *Whiten* case satisfied the *Vorvis* test. As enumerated by the court of appeal, the acts of Pilot Insurance that satisfied the *Vorvis* test included the following:

- Pilot deliberately ignored the opinion and recommendation of Derek Francis, an experienced adjuster it retained to investigate the fire loss.
- After receiving Francis' strong recommendation to pay the claim, Pilot replaced him.
- Pilot never provided Francis' reports to the experts that it later retained.
- Pilot asked the Insurance Crime Prevention Bureau to investigate, but when the Bureau concluded that Pilot had no defence to the claim, Pilot ignored the Bureau's conclusion.
- Pilot deliberately ignored the opinion of its engineering expert Hugh Carter, who gave three reports that the fire was accidental; and then Pilot refused to meet with Carter when he expressed concern that his opinion was being misunderstood.
- Pilot admitted that the jury could reasonably infer that Carter's later opinion reclassifying the fire as "suspicious, possibly incendiary," was influenced by Pilot's counsel.

¹⁶ *Ibid.* at 133-34.

- Pilot pressured its experts to provide opinions supporting an arson defence. Indeed, Pilot deliberately withheld relevant information from its experts and, instead, provided them with misleading information to obtain opinions favourable to its arson theory.
- Pilot even admitted that the jury could reasonably conclude the two later expert opinions supporting an arson defence were influenced by Pilot's counsel.
- Pilot accepted as justified the trial judge's comment that Pilot's counsel acted improperly in suggesting opinions to experts whose livelihood was earned by providing services exclusively to the insurance industry.
- Pilot used the bad faith claim by the Whitens to refer to evidence of previous fires-evidence it now concedes was irrelevant and inadmissible – in order to convince the Whitens' counsel that trial was risky.
- At every stage Pilot considered that it could safely deny the claim because the Whitens would not refuse an offer in the future. No representative of Pilot testified why the claim was denied and therefore the jury could reasonably infer that their testimony would not have shown that Pilot had a valid reason for denying the claim.
- When the Whitens had lost everything in the fire and when they were unemployed and on welfare, Pilot terminated the rent payments on their rented cottage and did so without telling them.¹⁷

Given this summary of Pilot's actions, it seems clear that punitive damages, under the *Vorvis* test, were not justified. Recall the comments made by the judge in the *Richardson* case, quoted above, that punitive damages may be avoided where the insurer has a justified scepticism about the claim, and the evidence in the plaintiff's favour is not properly characterized as "overwhelming". It appears, from reading the *Whiten* decision, that the evidence was overwhelmingly in favour of the plaintiff and the insurer had *no* justified scepticism about the claim.

The bad news, about the *Whiten* trial decision, for the disability insurer, was the amount of punitive damages awarded and the factors that went into the amount awarded. As indicated by Matlow J, in refusing to interfere with the one million dollar punitive damages award:

In light of the defendant's admission that its net worth was approximately 231 million, I cannot take issue with the jury's conclusion that a very substantial award for punitive damages was required to punish the defendant and to effectively send the implied reminder to the defendant and to other insurers that they owe their insureds a duty of good faith in responding to claims made under policies of insurance issued by them.¹⁸

¹⁷ *Supra* note 2 at 294-95.

¹⁸ *Supra* note 1 at 572.

Shortly after the trial decision in *Whiten* came down, I received a letter, from plaintiff's counsel in one of my cases, which contained the following comment:

The Pilot Insurance case allows a specific calculation. Using that formula and the material from the 1995 Sun Life Annual Report, it appears that, for these [punitive] damages alone, your client owes my client \$383,800,000.62. If your client would immediately remit a cheque in that amount to my client, we could put this dreary issue behind us.

All humour aside, Matlow J's comments, quoted above, did cause visions, in large disability insurers' heads, of punitive damages along Rainmaker lines. This concern was somewhat alleviated by the court of appeal reducing the punitive damages award to \$100,000.00, and also by its reasoning in doing so. Thus, the majority approved the following passage:

While punitive damages...may embrace such factors as the heinousness of the civil wrong, its effect upon the victim, the likelihood of its recurrence, and the extent of the defendant's wrongful gain, the fact finder must be guided by more than the defendant's net worth...plaintiffs do not enjoy a windfall because they have the good fortune to have a defendant with a deep pocket.¹⁹

The majority did imply, however, that the one million dollar award might have stood had Pilot's behaviour been more than an isolated instance of condemnable conduct. The majority said the following:

In the case in appeal, there is nothing in the evidence to suggest that the conduct so rightly condemned was the product of a corporate strategy by the appellant insurer to avoid payment of all policy claims or to discourage its insureds from making claims. Nor is there any suggestion that the defendant has profited from its actions. Rather, it appears to have been an isolated instance for which the appellant's trial counsel should take full responsibility, both for the manner in which the claim was processed and because of the way that the trial was conducted. This certainly was the view of the trial judge. I will not repeat the excerpt of the trial judge's charge to the jury which is set out by Laskin JA in his reasons, but wish only to highlight that the trial judge blamed trial counsel for directing and co-ordinating the expert evidence in support of the meritless arson defence that was maintained to the bitter end by the defendant insurer.²⁰

It almost seems as if the court of appeal had the fictitious Great Benefit Life Insurance Company in mind when they made this comment. Pilot Insurance can thus take comfort in the fact that its conduct was not as reprehensible as that of the big-bad-insurer in the Grisham novel.

c. *Effect on Litigation of Law on Punitive Damages*

By way of summary, the test for punitive damages is still the strict one enunciated in *Vorvis* and there is no clear indication that this test is being watered down. The *Adams* case, with its peculiar facts (which do not appear

¹⁹ *Supra* note 2 at 307.

²⁰ *Ibid.* at 305.

to involve any malice), stands on its own, *Ferguson* is largely incomprehensible, and *Whiten* is based on and clearly satisfies the *Vorvis* test. As was said earlier about *Vorvis*, an insurer would have to work very hard at being "evil" to satisfy the test and *Whiten* is an example of just how much work this involves. There is no case in Canada of a disability insurer working that hard at being bad, and the reasonable disability insurer, while avoiding complacency, need not lose too much sleep about punitive damages.

Having said that, it is clear that the possibility of a punitive damages award has changed the way plaintiffs' counsel approach disability cases. It was not too long ago (i.e. pre-*Adams*) that plaintiffs' counsel were often completely uninterested in even examining a representative of the insurer for discovery. The case was seen by both sides largely as a battle of the expert medical witnesses and the manner in which a claim was handled was not thought particularly relevant.

Now, plaintiffs' counsel typically spend hours in examining a representative of the insurer, poring over every hand-written note to find the motivating factors behind each word.²¹ At trial, in addition to calling medical experts, the insurer, where punitive damages are claimed, is obligated to put its claims examiner on the stand to go through the whole claims file and explain how each decision or move was justified by medical or other evidence and not based on irrelevant factors or malice. Indeed, in the recent case of *Flewelling v. Blue Cross Life Insurance Co.*,²² both the plaintiff and defendant called punitive damages experts to testify. The plaintiff called an American expert Haig Neville to opine on how a claims file should be handled and the defendant countered with its own claims-handling expert to testify that the insurance company's handling of the claim was appropriate and indeed "in excess of industry standards".²³

Even where there is nothing even remotely punitive about how a claim has been handled, plaintiffs' counsel, as a tactical device, are claiming punitive damages and pushing hard for them. The hope is that the insurer will pay the claim in full prior to trial to avoid the prospect of punitive damages being awarded. The tactic is continued at trial to give the judge a way of "sawing off" the action, i.e. find for the plaintiff on the issue of total disability but find for the insurer on the issue of punitive damages. Obviously, these tactics and the other developments just mentioned, along with their obvious spin-offs (as in acrimonious contested motions) are increasing the time and cost of litigating disability claims.

²¹ For example, we have been taken to task for ordering a "fair-weather surveillance", as if there were something sinister about not wasting our surveillance dollars during rainstorms or -30°+degrees weather).

²² Unreported, [1999] A.J. No. 381 (Alta. Q.B.).

²³ *Ibid.*

V. Aggravated Damages

a. *Prior to Court of Appeal Decision in Warrington*

As discussed above, *Vorvis* requires an independently actionable wrong before punitive or aggravated damages may be awarded. And, as we have seen, in the disability insurance context, the independently actionable wrong that may exist is a breach of the duty of good faith owed by the insurer to its insured. And since an entitlement to punitive damages against an insurer requires more than a mere breach of the duty of good faith, but also requires the breach to constitute a reprehensible form of conduct, one would expect aggravated damages to be more prevalent than punitive damages.

This inference is not really supported by the case-law prior to the Court of Appeal decision in *Warrington v. Great-West Life*.²⁴ However, there are a couple of cases which merit discussion.

The trial decision in *Warrington v. Great-West Life*²⁵ is one such case. In *Warrington*, the insurer's denial of disability insurance benefits was based on surveillance which, on February 17, 1993 showed the plaintiff cleaning a vehicle, and, on February 18, 1993, showed the plaintiff bolting a canopy to the box of the vehicle. The plaintiff was a bookkeeper with fibromyalgia and, in addition to its reliance on the videotape and its belief that the plaintiff could do a sedentary job, the insurer was also concerned (as evidenced in an internal memo) that "if benefits are paid, even in a settlement, it will become an issue in that area of the country".

This latter memo was pivotal in the court's finding of a breach by the insurer of its duty of good faith. As stated by the court,

....the defendant was motivated, at least in part, by considerations wholly extraneous to the entitlement of the plaintiff to benefits under the policy.²⁶

With respect to the surveillance, the court said the following:

The video was viewed in court. All the actions were carried out slowly and deliberately. Much of the time, the plaintiff barely moved. Unbeknownst to the investigator, the plaintiff had twice been hospitalized and received injections of pain killers in the three days prior to the incident. Also unknown to him, the plaintiff was bedridden with pain following these activities. Also unknown to him, the plaintiff was compelled to prepare that vehicle for sale because of dire financial circumstances caused by the defendant's failure to pay benefits.²⁷

In finding a breach of the duty of good faith, the court indicated that the insurer,

drew unfair negative inferences from that video without any inquiry as to whether those inferences were reasonable in the circumstances.²⁸

²⁴ (1996), 139 D.L.R. (4th) 18 (B.C.C.A.).

²⁵ (1995), 31 C.C.L.I. (2d) 256 (B.C.S.C.).

²⁶ *Ibid.* at 272.

²⁷ *Ibid.* at 265.

²⁸ *Ibid.* at 272.

This significance of the unfair inferences which the insurer drew from the video is similar to the unfair inferences which Confederation Life drew from its video of Ms. Adams. I argued, in that context, that one is not acting in bad faith in relying on a flawed surveillance video or report when the insurer does not know that it is flawed. However, given the comments in *Adams* and *Warrington*, disability insurers would be well-advised to do something to support the inferences they are drawing from the videotape, for instance, obtaining the clinical notes and records of the insured's physician to see if there were visits for pain-injections or other treatment at or near the period when the video was taken.

In addition to the irrelevant internal memo, and the unfair inferences from the video, the court found a number of other reasons for why the insurer had failed in its duty of good faith to the plaintiff. These reasons include: an initial acknowledgement that the claim was valid, followed by a denial two weeks later; the fact that all medical information was consistent with continuing disability; the fact the plaintiff's claim was, in part rejected, because there was, for a time a lack of diagnosis; the fact that, once the diagnosis of fibromyalgia was made, an assumption was made that the plaintiff fell into the majority of sufferers of fibromyalgia who are able to do sedentary work; and the fact that the insurer did not interview the plaintiff or obtain an independent medical examination until October of 1994. However, despite all these reasons, the court indicated that the insurer's conduct

does not meet this [*Vorvis*] standard of conduct deserving of punishment by way of punitive damages.²⁹

Instead, the court, having found that the plaintiff, after the insurer's termination of benefits, had to rely on the charity of family and friends as well as social assistance, awarded the plaintiff \$10,000.00 in aggravated damages.

Another disability insurance case where aggravated damages were awarded on the basis of a breach by the insurer of its duty of good faith, was *Evans v. Crown Life*.³⁰ In *Evans*, the plaintiff was a janitorial supervisor with rare disorders called cervical dystonia and cervical spondylosis which are not, in themselves, usually totally disabling. Even the court in *Evans* indicated the following:

The doctors are puzzled by the degree of pain experienced by Ms. Evans in relation to the relatively mild conditions affecting her.³¹

Complicating these conditions, were the additions of chronic pain and a chronic mood disorder all of which, in the opinion of Ms. Evans' doctors, rendered her disabled from working. The insurer appears to have recognized this disability, for it paid Mrs. Evans benefits for approximately five years well past the 24 month "own occupation" period and well into the "any occupation" period.

²⁹ *Ibid.* at 273.

³⁰ (1996), 37 C.C.L.I. (2d) 61 (B.C.S.C.).

³¹ *Ibid.* at 66.

One would think, therefore, that the insurer would have had a good reason for terminating benefits, after paying for all these years. A reading of the case, however, reveals no reason whatsoever. There was no change in Ms. Evans' condition; the insurer did not send her for an independent medical examination; there was no contact with Ms. Evans' physicians; and there was no suggestion of any specific occupation that Ms. Evans could perform. It appears that the termination of benefits was based on consultations with the insurer's in-house medical director.

In any event, the Statement of Claim was issued in March of 1995 and then, in March of 1996, the insurer amended its statement of defence to rely on an exclusion in the policy for mental/nervous conditions. In other words, two months before the trial of the action, the insurer came up with a theory justifying its position. The court found the following:

An insurer has a duty to an insured of good faith and fair dealing. The defendant has failed miserably in its duty to the plaintiff. The defendant has acted in a harsh and arbitrary manner toward the plaintiff. The effect on Ms. Evans has been profound, causing an exacerbation of her medical condition due to increased stress and anxiety resulting from the defendant's actions.

I award the plaintiff \$20,000.00 in aggravated damages.³²

There is no award of punitive damages in Evans and it is not clear whether they were included in the Statement of Claim.

I agree with the result in *Evans* and with the trial decision in *Warrington*. Assuring the evidence presented to the court was fairly described, in the court's reasoning (this is not always the case), then it is clear that the insurers missed the boat in terms of a responsible handling of the respective claims of Mr. Warrington and Ms. Evans. Although, the insurer's actions may be described as unjustified, a breach of good faith, or harsh and arbitrary, the fact is that the insurers did, or were found to have done something wrong. This wrong was a necessary condition for the award of aggravated damages. Another necessary condition was an actual aggravation of the plaintiff's condition, caused by the insurer's actions. In both cases, found this to have occurred. Therefore, following *Vorvis*, aggravated damages were awarded.

b. *Warrington on Appeal*

Both at the trial, and at the appeal, the issue of whether the plaintiff was entitled to aggravated damages was argued, relying on *Vorvis*. It was accepted by counsel for both sides that there would have to be an independent actionable wrong for aggravated damages to follow. The Court of Appeal, however, per Newbury J.A., approached the situation somewhat differently. Firstly, Newbury J.A. pointed to the existence of "peace of mind" cases, *Jarvis v. Swan Tours*,³³

³² *Ibid.* at 74.

³³ *Jarvis v. Swan Tours*, [1973] 1 Q.B. 233 (C.A.).

where damages for mental distress were awarded in a breach of contract situation where there was no apparent independent actionable wrong. Secondly, Newbury J.A. pointed out that McIntyre, J., in *Vorvis*, had used the phrase, "damages for mental distress, properly characterized as aggravated damages." Newbury, J.A. then concluded that:

I read *Vorvis* to mean not that "damages for mental distress, properly characterized as aggravated damages" will be awarded only where there is an independent wrong in addition to the breach of contract...but to leave it open to courts to develop guidelines as to the limited circumstances that will justify such awards.³⁴

Finally in Newbury, J.A.'s classified disability insurance contracts as "one of the few contracts in which damages for mental distress are recoverable when they are proven to result from the breach of contract." In other words, Newbury, J.A. categorized disability insurance contracts as "peace of mind contracts" where "an important benefit, and indeed a purpose, of [the] contract [is] the "peace of mind" implicit in the insured's receipt of timely and reliable benefit payments in substitution for his or her wages".³⁵

Although the British Columbia Court of Appeal left the quantum of the aggravated damages awarded at \$10,000.00, it indicated that this amount had nothing to do with a "wrong" that might have been committed by the insurer. This was recognized by Newbury, J.A.:

...logically, Mr. Warrington's mental distress did not result from Great-West's motive or bad faith (or breach of a duty of good faith) or mental state or motives in refusing Mr. Warrington's claim. It resulted from the delay itself. The effect on him would have been the same whether the insurer had been well-motivated, reasonable, unreasonable, or even malicious in that delay. Thus in my view it was erroneous to find that an independent tort had been proven that resulted in injury in the form of mental distress to Mr. Warrington.³⁶

Newbury, J.A. went on to express that it was,

unnecessary to determine whether there is a duty...of good faith, the breach of which is an independent wrong, owed by insurers to their insureds with respect to the payment of benefits.³⁷

There is much food for thought in Newbury, J.A.'s reasoning. First, her interpretation of *Vorvis* as leaving the door open for awards of aggravated damages in the absence of independent actionable wrongs is questionable. *Vorvis* is generally interpreted as *the* case that limits aggravated and punitive damages by requiring independent actionable wrongs. Furthermore, at least in the context of group disability-insurance, where the insurance benefit is simply one component of the insured's employment contract, Newbury, J.A.'s reasoning appears to conflict with that of the Supreme

³⁴ *Supra* note 22 at 29.

³⁵ *Ibid.* at 29.

³⁶ *Ibid.* at 31.

³⁷ *Ibid.* at 31.

Court of Canada in *Wallace v. United Grain Growers Ltd.*³⁸ In that case the court said the following:

An employment contract is not one in which peace of mind is the very matter contracted for ... and so, absent an independently actionable wrong, the foreseeability of mental distress or the fact that the parties contemplated its occurrence is of no consequence...³⁹

Further, in *Sylvester v. B.C.*⁴⁰ that, "...the L.T.D.P. [long term disability plan] should not be considered contracts which are distinct from the employment contract, but rather as integral components of it", then it seems that Newbury, J.A.'s characterization of disability contracts as "peace of mind contracts" may not be in accordance with what the highest court in our land thinks. Of course, this critique of Newbury, J.A.'s views would not apply to individual disability insurance contracts which are, in no way, part of an employment contract. Thus, it is necessary to analyse the whole notion of "peace of mind contracts" and the inclusion of disability contracts in that category.

It is difficult to find any well-defined category of "peace of mind" contracts. When I am contracting for a trip to Hawaii for my vacation, the object or primary purpose of the contract is to get the requisite flight, hotel, and meal-plan. Obviously, I am also hoping for a break from work, and in that sense some peace of mind is incidental to what I am contracting for, but it is difficult to distinguish the "vacation cases" from many other contracts in this regard. For example, peace of mind an outmost concern for my wife and myself, when we bought our first cell-phone. Nonetheless, the object of the contract was a phone and the cellular service offered by the phone company. I have yet to see a contract for a cell-phone describe as a peace of mind contract. The Michelin company explicitly markets its tires as providing peace of mind with pictures of babies and the slogan, "Because so much is riding on your tires." Yet, a tire-contract has never been legally characterized as a peace of mind contract, the breach of which could lead to aggravated damages. Any number of other examples can be found where peace of mind is the motivating force in purchasing objects, that may be quite mundane. People buy umbrellas in case of rain, maps in case they get lost, cars to avoid having to take public transit at night, generators in case Y2K problems shut down the power grid, or whatever. Are all of these to be considered peace of mind contracts?

No doubt, peace of mind considerations can play a part, perhaps even be the motivating force, in purchasing long-term disability insurance. In this respect, these contracts are no different than contracts for the purchase of tires, umbrellas, or generators. What one gets when one contracts to buy a generator is the generator, and perhaps some peace of mind. Similarly, when one contracts to purchase long-term disability insurance, what one obtains is a contract of indemnity for loss of income should he or she become totally disabled, and

³⁸ (1997), 152 D.L.R. (4th) 1.

³⁹ *Ibid.* at 27.

⁴⁰ [1997] 2 S.C.R. 315 at 321.

possibly, one also obtains some peace of mind. I say “possibly” because I suspect that, in the majority of group-insurance cases, the employee, until he or she needs it, pays no attention to disability insurance coverage. Employees choose jobs primarily, because of the type of work they will be doing and because of the salary. If they think at all about group-insurance benefits, these thoughts do not play a major factor in entering into the employment contract. Again, different considerations go into the purchase of an individual policy of disability insurance and these, admittedly, can more appropriately be called “peace of mind” contracts. Nonetheless, in my opinion, it is still difficult, if not impossible, to distinguish them from contracts for all sorts of other rights and items.

This criticism is of the whole concept of peace of mind contracts. This means, unfortunately, that it is a criticism of a well-established line of cases (*Jarvis v. Swan Tours*) which is not likely to get overruled anytime soon. Assuming that peace of mind contracts are here to stay, are there any arguments for bringing purchases of long-term disability insurance, as opposed to generators, within that category? For the reasons given above, I do not think so. The *Jarvis* line of cases is logically incoherent, cannot be expanded in any logical fashion, and should, therefore, not be expanded at all.

Also of some concern is Newbury, J.A.’s reasoning that “Mr. Warrington’s mental distress did not result from Great-West’s motive or bad faith”. Although it may well be the case that the good-faith actions of a reasonable insurer will lead one to have to borrow from relatives or go on welfare, it seems to me that there is a significant difference between these consequences being unintentionally or maliciously caused. This is not rocket science. If my four year old daughter accidentally spills a glass of milk on me I feel a certain way. However, I feel a lot more aggravated if she has purposely thrown the milk at me. In the first case, I may ask my daughter to help clean up the “damage”; in the second case I will likely ask her to do that plus impose an additional sanction. By analogy, I would argue that no “additional sanction” is necessary where a good-faith denial of an insurance claim has been made but a court has ultimately found the insured to have been entitled to the benefit. In that case the payment of the benefit, plus interest and costs, is sufficient to address the situation.

c. *The Aftermath of Warrington*

The Warrington “peace” of mind reasoning has been followed in other cases in British Columbia, most notably in *McIsaac v. Sun Life*,⁴¹. In that case, counsel for Sun Life explicitly argued that Newbury, J.A.’s reasoning in Warrington was inconsistent with that of the Supreme Court of Canada in *Wallace v. United Grain Growers*. The court of appeal disagreed, found that *Wallace* was distinguishable, and upheld the trial judge’s award of \$8,500.00 for damages for mental distress.

⁴¹ (1999), 173 D.L.R. (4th) 649. See also *Eddie v. Unum Life Insurance Co.* (B.C.C.A. 9/9/99 unreported).

However, the Warrington “peace of mind” reasoning has not yet gained a foothold in other provinces. Indeed, in Ontario, the Court of Appeal has, in the case of *Schmidt v. Coatings 85 Ltd.*,⁴² reaffirmed the *Vorvis* proposition that an independent actionable wrong is necessary for an award of aggravated or punitive damages. Thus, in the *Schmidt* case, the court approved of the following statement:

Aggravated damages are compensatory, while punitive damages, as the name implies constitute a punishment imposed upon a person by the courts. Before either aggravated or punitive damages can be awarded, a separate actionable wrong must be demonstrated by the plaintiff.

Similarly, in the above-referenced case of *Flewelling v. Blue Cross*, the court said the following:

There is no evidence on which a claim for bad faith can be founded. It therefore follows that there is no basis on which to award exemplary, punitive or aggravated damages.⁴³

VI. Conclusion

As long as punitive and aggravated damages are awardable only following the *Vorvis* test, disability insurers who act fairly will be treated fairly. Although my fictitious namesake in the *Rainmaker* was able to secure a fifty million dollar award against an insurer for bad faith, the prospect of punitive damages awards on this scale in Canadian disability cases seems remote.

A final concern is the “peace of mind” reasoning in the context of aggravated damages. This can lead to an award of aggravated damages against an insurer who has acted reasonably and in the best of faith. Again, further developments in this area are awaited from the Supreme Court of Canada.⁴⁴

⁴² (1999) 88 A.C.W.S.(3d) 392 (Ont. C.A.)

⁴³ *Supra* note 22.

⁴⁴ But it will not derive from the *McIsaac* case as leave was denied 23.12.99.