

EXPLAINING JUDGES' "OBSESSION" WITH THE ONUS OF PROOF IN DISABILITY CASES

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The issue of onus of proof has played a large role in cases where judges have had to decide an individual's entitlement to long-term disability insurance benefits. The explanation for this appears to be that judges are increasingly presented with allegedly disabling illnesses which cannot be objectively evaluated. This makes it difficult for both plaintiff and defendant to prove anything; hence, the issue of who has the burden of proof is in the forefront of such cases. This paper examines the trends evident in the case-law and suggests an alternative procedure for the judiciary.

La question du fardeau de la preuve a joué un rôle important dans les affaires où les juges ont dû devoir décider du droit d'un individu aux bénéfices d'une assurance-invalidité à long terme. La raison en est, semble-t-il, que de plus en plus, les juges se trouvent devant des allégations de maladies causant une invalidité dont la preuve ne peut pas être évaluée objectivement. Il est donc difficile de vraiment prouver quoi que ce soit pour le demandeur et le défendeur. D'où le rôle de premier plan de la question du fardeau de la preuve dans ces affaires. Cet article examine les tendances qui se dégagent de la jurisprudence et suggère une solution de rechange pour les juges.

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I. Introduction

Virtually every reported decision on a plaintiff's claim for long-term disability insurance benefits contains a section on the issue of onus of proof. For example, the Alberta case, *Adams v. Confederation Life Insurance Company* is well-known for being the first disability insurance case in Canada where punitive damages were awarded; what is less well-known about the decision is that it contains almost seven full pages on the issue of onus of proof.¹ The Ontario decision in *Hamilton v. Constellation Assurance* is known for applying common-law principles of mitigation to the disability insurance context: less well-known, perhaps, is the fact that the decision contains over five full pages on the issue of onus of proof.² Other cases, some of which will be discussed below, have longer sections on the onus of proof, and some have shorter ones, but every case in this area of law seems to have at least a couple of paragraphs on the issue.

On the face of it, this is most surprising. As stated by Madam Justice Epstein in *Ritch v. Sun Life Assurance Co. of Canada*:

...the practical issue of how to assign the burden of proof arises only in those situations where the process of weighing the evidence has produced no result....However, as can be seen from my analysis of the evidence, I was not left with any lingering doubt as to the effects of Ms. Ritch's medical condition, and so I did not have to consider burden of proof to make my decision.³

The above statement by Madam Justice Epstein comes at the end of an 8-paragraph section entitled "Onus of Proof"; so, although the issue of who has the burden of proof did not influence her decision in the case, she, too, spent some time discussing the legal issue.

It seems clear that Madam Justice Epstein is correct in saying that the issue of burden of proof only arises where the weighing of evidence produces a "tie". Given the judicial propensity to discuss the issue of onus of proof in disability cases, does this mean that most of these cases leave the judge with lingering doubts about the correct outcome, which tend toward the "tie" result? In my view, the answer to this question is "yes". The argument of this paper will be that, given the increasing "subjectivity" of the illnesses claimed by plaintiffs to be totally disabling, it is becoming near impossible for either the plaintiff or defendant to prove anything. In these circumstances, the issue of who has the onus of proof becomes a significant one. Support for this argument arises, first of all, in the fact that the law of onus of proof in disability cases is "all over the map", something we might expect if the issue were playing an important role over a wide variety of cases.

¹ *Adams v. Confederation Life Insurance Co.* (1994), 25 C.C.L.I. (2d) 180 at 192-98 (Alta. Q.B.).

² *Hamilton v. Constellation Assurance Co.* (1989), 40 C.C.L.I. 185 at 190-95 (Ont. Dist. Ct.).

³ *Ritch v. Sun Life Assurance Co. of Canada* (1998), 8 C.C.L.I. (3d) 228 at 232 (Ont. Gen. Div.).

II. Who has the onus of proof?

What follows is a brief, general description of the current state of the law of "onus of proof" in disability insurance cases. If the reader wishes a more detailed description, citing most of the relevant cases, he or she should refer to the relevant section of Hayles on Disability Insurance.⁴ We begin with the simple proposition that a plaintiff, in any civil case, has the legal burden of proving his or her case on the balance of probabilities. This simple proposition appears to apply simply only in a disability insurance case where the insurer has never paid any disability benefits to the plaintiff. In those circumstances, the legal burden, at all times, is on the plaintiff to prove his or her entitlement to those benefits.

Things become a little less clear where the insurer has made some payments. Various scenarios present themselves. The next "clearest" scenario is where the insurer has not paid any disability benefits under a particular policy definition of total disability. Although even here there is the odd case going the other way, it is generally thought the plaintiff has the legal burden of proving his or her entitlement under that definition. I am here, of course, thinking of the common situation where a disability insurance policy has an "own occupation" period, followed by an "any occupation" period. Typically, during the own occupation period, which usually lasts two years, the insured is entitled to benefits under the policy if he or she is incapable, due to sickness, illness or bodily injury, from performing his or her own job or occupation. Thereafter, the any occupation period commences under which, typically, an insured is entitled to benefits if incapable of performing, or becoming able to perform, a reasonably commensurate occupation. Obviously, the precise terms of the relevant insurance policy must be considered in each individual case; however, the preceding description of "typical" own occupation and any occupation tests are sufficient to make the point that, if an insurer pays benefits during the own occupation period, the legal burden to prove entitlement during the any occupation period has generally been thought to remain on the insured or plaintiff.

Things get murkier in the situation where the insurer terminates benefits before the end of either the own occupation period or the any occupation period. Three different lines of cases have developed. The first line of cases stands for the proposition that the insurer, having paid benefits under a certain policy definition, has the legal onus of proving that the insured no longer meets that definition. A recent case (post-Hayles) which stands for this proposition is the case of *Ritch v. Sun Life*, discussed earlier.

The second line of cases, purporting to govern the situation where a disability insurer has paid part-way into a disability period and then stopped, indicates that there is a shifting onus of proof beginning with the plaintiff and

⁴ R. Hayles, *Disability Insurance: Canadian Law and Business Practice* (Toronto: Carswell, 1998) at 321-31.

moving to the insurer. Indeed, there are a few cases which suggest there is a shifting onus even when the insured has paid no benefits or only paid until the end of the own occupation period. In any event, the "shifting onus" body of case law is nicely exemplified in the following quotation from the recent Alberta case of *Flewelling v. Blue Cross Life Insurance Co. of Canada*:

There is a body of decisions that stand for the proposition that the initial onus is on the plaintiff to prove that she fits within the wording of the disability section of the policy and by not accepting her claim the insurer is in breach of the policy. That onus is satisfied if the insured establishes on a balance of probabilities that she comes within the terms of the policy. Thereafter, the onus shifts to the defendant to prove that the plaintiff is capable of substantially performing her own occupation or any occupation depending on the terms of the policy. While there is some diversion of views when the insurer pays and later terminates benefits it would appear the same test applies, i.e. the insured has to initially establish the breach.⁵

The third line of cases follows the Nova Scotia Court of Appeal in *Porter v. Metropolitan Life Insurance Co.*⁶ In that case, the court said the following:

...it is my opinion that the burden is on the insured to prove that he was disabled both under the employee's occupation and the total disability portions of the policy. There was here no shifting burden caused by the insured making payments under the policy or for any other reason.⁷

According to Hayles, "...the overwhelming weight of recent authority in the Province [of Ontario] favours the *Porter* approach."⁸ Hayles seeks to reconcile the conflicting case law as follows:

...the plaintiff in a disability case has the burden at the opening of the trial of proving the allegations contained in the Statement of Claim. In other words, he must demonstrate facts which support his claim that he is entitled to benefits...

Proof of these facts would establish a *prima facie* case in favour of the plaintiff. At this point the evidentiary burden would shift to the defendant, who will be called upon to provide proof of its allegation that the plaintiff is no longer disabled. It could try to do this by showing that a medical examination was conducted prior to the decision to discontinue benefits which found the plaintiff fit for work....

Once the defendant has adduced *prima facie* proof of its defence, the evidentiary burden shifts back to the plaintiff...Although the evidentiary burden may shift several times during the course of the trial, the legal burden remains on the plaintiff throughout.⁹

Mr. Hayles' reconciliation makes eminent sense and I commend it to the reader and to the courts. The question of why it all matters remains unanswered. If the law of the onus on proof is only determinative in the case of a "tie", why all the fuss about it? Why have these different lines of case law developed? Why do judges in disability cases appear obsessed with the issue of onus of proof?

⁵ [1999] A.J. No.381(Alta. Q.B.).

⁶ (1985), 15 C.C.L.I. 45 (N.S.C.A.).

⁷ *Ibid.* at 55-56.

III. Subjective Conditions

As indicated above, in my view, judicial fascination with the onus of proof in disability cases arises, at least in part, from the fact that substantive proof of anything, from both sides, is hard to come by in these cases. The reason for this is that these cases most often involve a claim for disability benefits based on a "subjective" condition. A "subjective" condition is one where claimed symptoms or levels of disability can in no way be objectively, medically verified. This is the case for complaints of chronic pain, chronic fatigue, fibromyalgia, depression, etc. Soft tissue injuries which do not heal within the expected time-frame, e.g., chronic whiplash injuries arising out of a motor vehicle accident, would also come under the heading of "subjective" conditions. As stated by Dr. Robert Teasell, a well-known Ontario physiatrist, who has been called by plaintiffs' counsel on several occasions to testify in court in personal injury or disability litigation:

Like all patients with myofascial pain, patients with chronic whiplash injuries present with subjective symptoms which often appear out of proportion to the physical findings.¹⁰

It is important to stress Dr. Teasell's comment that the subjective symptoms are out of proportion to the physical findings. Using the term "subjective condition", I do not imply that there are no physical findings. For example, magnetic resonance imaging (MRI) of a person alleging totally disabling back pain may well indicate the presence of disc bulges or protrusions. One cannot, however, interpret these physical findings as the cause for the alleged back pain, as a large percentage of people without any back pain have disc bulges or protrusions. As concluded by one study in the *New England Journal of Medicine*:

On MRI examination of the lumbar spine, many people without back pain have disc bulges or protrusions but not extrusions. Given the high prevalence of these findings and of back pain, the discovery by MRI of bulges or protrusions in people with low back pain may frequently be coincidental.¹¹

The existence and severity of subjective conditions, therefore, remains to be determined mainly by evaluating the subjective complaints of the plaintiff.

⁸ Hayles, *supra* note 4 at 328.

⁹ *Ibid.* at 330.

¹⁰ R. Teasell & A. Shapiro, "Cervical Whiplash Injury", H. Vaeroy & H. Merskey, eds., in *Progress In Fibromyalgia and Myofascial Pain* (New York, Elsevier Science Publishers, 1993) at 253.

¹¹ M. Jensen *et al.* "Magnetic Resonance Imaging of the Lumbar Spine in People Without Back Pain" Merskey, eds., *New England Journal of Medicine* 331:2 (14 July 1994).

IV. *Plaintiffs' subjective complaints*

Assuming that the plaintiff has the initial onus of proving at least a *prima facie* case of total disability, courts must decide whether the plaintiff's subjective complaints are sufficient to meet this *prima facie* burden. Some courts have been sceptical about subjective complaints constituting such proof. Thus, in the British Columbia case of *Butler v. Blaylock Estate*, the Chief Justice of the Supreme Court said the following:

I am not stating any new principles when I say that the Court should be exceedingly careful when there is little or no objective evidence of continuing injury, and when complaints of pain persist for long periods extending beyond the normal or usual recovery period.¹²

More recently, the Court of Appeal of British Columbia has expressed similar sentiments as follows:

While it is possible that a judge could find such a claim to be proven on the plaintiff's own evidence alone, it is clear in my view that the test is not entirely subjective. Sucharov establishes that proof of total disability must be sufficient to satisfy the reasonable man, the traditional objective test. For that reason, acceptance by the trial judge of objective medical evidence of total disability will usually be required.¹³

And there are good reasons not to uncritically accept the subjective complaints of the plaintiff. As stated by Edward Shorter, in the case of the subjective condition of chronic fatigue:

A whole subculture of chronic fatigue has arisen in which those patients too tired to walk give each other hints about how to handle a wheel chair and exchange notes about how to secure disability payments from the Government or from Insurance companies.¹⁴

On examination for discovery, plaintiffs often admit that they are members of Fibromyalgia or Chronic Fatigue Associations that do indeed provide advice on the matters referred to by Mr. Shorter. Moreover, the testimony given by these plaintiffs, on their inability to work, is, from my experience, essentially the same whether their alleged illness is chronic pain, fibromyalgia, chronic fatigue, etc.. These plaintiffs generally testify to the effect that they have good days and bad days, with more bad than good, that their symptoms are unpredictable, that they're capable of many activities, and sometimes even capable of being active several days in a row, but these periods of activity may fatigue them for days. Basically, they say there is no way they could report regularly to any job, day in and day out. I will hereinafter refer to this type of testimony as the "good days-bad days testimony". I have no doubt left out some of the characteristics of the

¹² [1991] B.C.J. No. 31.

¹³ *Mathers v. Sun Life Assurance Co. of Canada* (1999), 9 C.C.L.I. (3d) 151 at 154 (B.C.C.A.). Leave to appeal to Supreme Court of Canada refused March 16, 2000, 253 N.R. 399.

¹⁴ E. Shorter, *From Paralysis to Fatigue-A History of Psychosomatic Illness in the Modern Era* (New York: Maxwell Macmillan, 1992) at 307.

good days-bad days testimony: however, anyone who works in this area will have regularly experienced the type of testimony I am talking about.

So I agree with the *Blaylock* and *Mathers* decisions that we must not uncritically accept subjective complaints of the plaintiff in a disability case. Further grounds for at least some scepticism stems from the fact that litigation itself appears to cause plaintiffs with subjective conditions to amplify their symptoms. A 1996 study co-authored by Dr. Teasell found the following:

...current litigants reported pain in significantly more body sites, higher pain severity, and reported that more activities caused an increase in their pain than post litigants.¹⁵

It is also somewhat significant, in this context, to remember that the "diagnosis" of certain subjective conditions, such as fibromyalgia or chronic fatigue syndrome, is still somewhat controversial in the medical community. This was recognized in the case of *Mackie v. Wolfe* where, on the medical evidence presented to it, the court said the following:

The evidence here convinces me that the medical profession itself would not say that fibromyalgia, on the balance of probabilities, exists...I am satisfied that fibromyalgia has become a court-driven ailment that has mushroomed into big business for plaintiffs, particularly in British Columbia and Saskatchewan.¹⁶

However, attempting to deny the existence of a subjective condition such as fibromyalgia or chronic fatigue syndrome would currently be a risky trial strategy. Not only have there been a myriad of cases recognizing fibromyalgia as a potentially disabling syndrome, but there is a recent Ontario case which predicts that the syndrome will one day become "objective" and achieve disease-status. Thus, in the case of *Jones v. The Prudential Group Assurance Company of England (Canada)*, Cusinato, J. said the following:

During the trial we have heard orally from a number of medical experts, as well as the medical views filed with the court. These all deal with Fibromyalgia, as a syndrome in which the visual observations do not identify the problem. The complaints are not examinable, and the term therefore used, is that the complaints are subjective in nature, but this does not mean a disease does not exist. It is only that science concerning the human body with all the advances made remains still imperfect as to the causes or basis for many of the human complaints with this disease. Fibromyalgia is classified as a syndrome, because science has not yet perfected an objective diagnosis for this disease.¹⁷

It remains to be seen whether His Honour's predictions come true. However, even if an objective cause for fibromyalgia (or any other currently "subjective" condition) were found, this would not, by itself, determine the issue of total

¹⁵ L. Swartzman, R. Teasell *et al.*, "The Effect of Litigation Status on Adjustment to Whiplash Injury" *SPINE* 21:1 (1996) at 56.

¹⁶ *Mackie v. Wolfe* (1994), 153 A.R. 81 at 138 (Q.B.), *aff'd* (1996), 184 A.R. 339 (C.A.).

¹⁷ *Jones v. Prudential Group Assurance Company of England (Canada)* (1999), 13 C.C.L.I. (3d) 62 at 75-76 (Ont. S.C.J.).

disability. All sorts of persons, suffering from all sorts of objective diseases, are capable of and are engaged in full-time work. Just because one has a heart disease (or almost any other objective disease) does not mean one is totally disabled. The disability insurer's mantra, "diagnosis does not equal disability" is completely true. And although, as I indicated above, I would be hesitant to deny the existence of subjective conditions such as fibromyalgia, I would not be at all hesitant to call medical evidence as to the likelihood of these conditions being totally disabling. Perhaps the best evidence in this regard, at least with respect to fibromyalgia, is that proffered by Dr. Frederick Wolfe. Dr. Wolfe is fairly described as one of the "inventors" of fibromyalgia in the sense that he was the lead doctor in developing the American College of Rheumatology Guidelines for "diagnosing" fibromyalgia.¹⁸ More recently, however, in an article entitled "The Fibromyalgia [FM] Problem", Dr. Wolfe says the following:

It began almost imperceptibly, but now, after logarithmic growth, FM is out of control. FM cases have reached near epidemic proportions in the courts, in U.S. social security disability claims, workers' compensation and accident litigation.¹⁹

Dr. Wolfe's comments echo those of the trial judge in *Mackie v. Wolfe*, discussed above. And indeed, while never denying the existence of the fibromyalgia syndrome, Dr. Wolfe goes on to say the following:

The Israeli experience, where work disability is not approved of, and the Australian experience, where small changes in the law snuffed out an epidemic of repetitive strain injury claims, suggest that we may be able to control the incipient FM epidemic as well. To start, I suggest that we abolish disability awards based on the diagnosis of FM. That will keep FM a clinical entity, as it should be, and will stop the necessity for proving the presence of a certain number of tender points, a notoriously unreliable and manipulable exercise. That is, we should keep FM a chronic pain syndrome. Second, we should consider limiting the duration of payments for generalized chronic pain syndrome. For example, for claimants judged disabled by a chronic generalized pain syndrome, claimants might be limited to a period of one to two years. The goal of such limitation would be to help the claimant during the time of difficulty, to prepare to return to her original job or to work that now might be more physically suitable. That is, we should use disability benefits in this syndrome as an opportunity for retraining or the acquisition of other skills required in the workforce. Current evidence regarding FM suggests that disability awards rarely result in clinical improvement....What might happen if this suggestion were implemented? I would hope that claims would decrease, and that patients would be encouraged to get better rather than to see themselves as disabled.²⁰

¹⁸ F. Wolfe *et al.*, *The American College of Rheumatology 1990 Criteria for the Classification of Fibromyalgia: Report of the Multi-Centre Criteria Committee*. *Arth Rheum.* 1990:33:150-172.

¹⁹ F. Wolfe, "The Fibromyalgia Problem" (editorial), *J Rheumatology* 1997:24:1247-9 at 1247.

²⁰ *Ibid.* at 1248-49.

Dr. Wolfe ends his article with the exhortation that, "We must halt the trend to label patients with FM as disabled, and we must interfere with the societal trend toward encouragement of the disability concept."²¹

The epidemic described by Dr. Wolfe in the United States also exists in Canada. A 1989 study estimated that over \$200,000,000.00 per year in long term disability claims is paid out by Canadian insurers for fibromyalgia alone.²² From my personal experience, the "epidemic" in Canada has certainly not subsided since 1989.

The recent Canadian medical literature also supports Dr. Wolfe's thesis that fibromyalgia is not, generally, a disabling syndrome. In 1996, the Quebec College of Physicians put out a consensus paper indicating the following:

Fibromyalgia should not be a disabling condition it itself. Initially, if one is given a work-leave, it should be short (usually less than one month), and its duration should be clearly established beforehand with the patient. The specific reason as well as the goal targeted should be rigorously documented in the file. A work leave can, for example, be presented as a short respite period during which the patient will begin to learn how to manage the disease (obtaining information, undertaking an exercise program, putting pacing into practice). The patient should avoid using this period to rest or recover. The timetable for returning to work should be respected even if the symptoms have not resolved completely.²³

It is submitted that, for all of the above reasons, courts would often be justified in taking a very critical approach to assessing a plaintiff's self-reports of pain, fatigue, depression, etc. before believing the plaintiff and finding him or her totally disabled. And one such critical approach would be to put a fairly heavy onus on the plaintiff even to establish a *prima facie* case of total disability. *Mathers* can be interpreted as such a case, one where the issue of onus of proof rears its head to require objective proof.

Having said this, even the *Mathers* case does not preclude finding total disability based on self-reports alone, and courts have, on occasion, done just that. Thus, the trial decision in *Eddie v. Unum Life Insurance Co. of America* says the following:

I conclude that the meaning of "sickness" in this disability insurance policy includes the condition of a person who genuinely wants to continue in his or her employment but, because of a perception, based on symptoms, that something is wrong with his or her body, genuinely and reasonably feels unable to do so. This is a substantially subjective test and depends on the credibility of the claimant.²⁴

²¹ *Ibid.* at 1249.

²² G. McCain *et al.*, "The Problem of Long Term Disability Payments and Litigation in Primary Fibromyalgia: The Canadian Perspective" *J. Rheumatology* 1989:16:174.

²³ Quebec College of Physicians and Surgeons, Consensus Paper, "Fibromyalgia" (June 1996).

²⁴ *Eddie v. Unum Life Insurance Co. of America* (1998), 4 C.C.L.I. (3d) 223 at 231 (B.C.S.C.).

Obviously, the plaintiff's success at trial was achieved by applying an onus of proof much more easily satisfiable than the one imposed in *Mathers*. Unum's appeal to the British Columbia Court of Appeal was dismissed, but, in dismissing the appeal, the court also distanced itself from the reasoning of the trial judge that a plaintiff's own perception of disability could satisfy the policy test. The concurring reasons of Hall J.A. contained the following reasoning:

I would also say that if the trial judge's reasons commencing at para. 46 can be interpreted as suggesting that a person's own perception should lead to a finding of disability based on illness, that is not a proposition I would agree with. I should think some expert medical evidence would always be necessary to assist the trier of fact. I would state my conclusion about liability in this case as follows. There was convincing evidence in this case from the plaintiff, from a number of other lay persons familiar with her circumstances at the relevant time and from treating and consultant physicians to establish to the necessary degree of proof that she was too ill to engage in work. Accordingly, she was disabled and entitled to benefits under the group policy of disability insurance.²⁵

V. *Medical evidence relating to subjective conditions*

As was just discussed, the Court of Appeal in the *Eddie* case thought that a combination of the plaintiff's own evidence, medical evidence, and the evidence of lay witnesses satisfied the onus of proof. At first blush, this sounds like the imposition and satisfaction of a reasonably difficult burden. The problem with, first of all, considering medical evidence in subjective cases is that the subjectivity of the case flows through into the medical evidence. In other words, a doctor describing a patient's pain or fatigue can do little more than repeat what the patient says about the pain and fatigue. Using the popular business term "value-added", no matter how impressive a doctor's credentials or resume are, he or she can add little value to the proof of a patient's subjective complaints. Most doctors, upon being cross-examined, will readily admit that their opinions or reports, in subjective cases, are based almost entirely on what their patient tells them. Unless and until they have a reason to disbelieve their patient, they believe what they are told and transcribe it. In effect, their "expert testimony" on a particular plaintiff's condition is almost pure hearsay and certainly infected with the subjectivity that characterizes the conditions we are discussing. This was recognized by Prowse J. A., who wrote the primary majority reasons in the *Eddie* appeal decision, as follows:

...the medical evidence called on behalf of Ms. Eddie in support of her claim that she was disabled from working was largely dependent on her subjective description of her symptoms and their effect upon her,...²⁶

²⁵ *Eddie v. UNUM Life Insurance Co. of America* (1999), 13 C.C.L.I. (3d) 1 at 30 (B.C.C.A.).

²⁶ *Ibid.* at para. 46.

Having recognized that the medical evidence was based on the plaintiff's self-reports of her symptoms, Prowse, J. A. went on to point out that "there was evidence from others verifying the apparent effect of her condition on her day-to-day living and her ability to work. The credibility of these witnesses was not challenged."²⁷

VI. Lay Witnesses

It appears, then, that it was the evidence of lay witnesses that helped satisfy the burden of proof in the *Eddie* case. In a recent case called *Maleschuk v. Sun Life*, the plaintiff was awarded disability benefits largely on the strength of the testimony of his wife. Thus Cavarzan J. said, "I place great weight on the testimony of Sharon Maleschuk who was an observant and articulate witness."²⁸ Similarly, in the case of *Spring v. Saley*, the Ontario Court of Appeal said the following:

In our opinion it was open to the trial judge to look to lay witnesses to assist in determining the onset of disability. There is nothing in the policy to require medical evidence and we would not read such a requirement into it.²⁹

One would think that such evidence should, *prima facie*, be discounted. The family and friends of the plaintiff always have a financial and/or emotional incentive to support the plaintiff and thus their evidence cannot be considered wholly unbiased. In any event, if it is such testimony that gets the plaintiff "over the top" in terms of his or her burden of proof, one would think that the insurer would have a reasonable chance at calling enough substantive evidence to satisfy its evidentiary burden and throw the ball back into the plaintiff's court.

However, plaintiffs are successful in the majority of long-term disability cases against insurers. Given that plaintiffs generally offer very little concrete proof of anything, namely self-reports, echoed by the plaintiffs' doctors and supplemented by evidence of lay witnesses who are hardly independent, this result appears surprising. One would think that insurers could easily proffer the same type, quality and amount of evidence. But again, given subjective conditions, the insurer has the same problems of providing concrete substantive proof as the plaintiff has. In order to prevent the problems of proof on both sides from ending in the "tie" situation, the concept of the burden of proof has been evoked to, generally, give plaintiffs the edge. In other words, the evidentiary burden put on the defendant/insurer has, traditionally, been a heavier one than that put on the plaintiff. The easily achievable actual burdens applied on the plaintiff in *Eddie*, *Maleschuk* and *Saley*, are examples of this. The following section will discuss the reasonableness of this situation and suggest a more reasonable evidentiary burden the defendant should have to meet.

²⁷ *Ibid.*

²⁸ *Maleschuk v. Sun Life Assurance Company of Canada*, [1999] O.J. No. 4913 at para. 28.

²⁹ *Spring v. A. Saley and Associates Ltd.* (1999), 13 C.C.L.I. (3d) 325 at 325 (Ont. C.A.).

VII. *The Defendant's Onus*

A couple of cases have placed an unreasonable and misguided evidentiary burden on the disability insurer. For example, the recent case of *Parker v. Saskatchewan Hospital Association* describes the onus on the respective parties as follows:

The onus is on Ms. Parker, on a balance of probabilities, to establish that as of July of 1994, she was totally disabled within the definition of the disability plan (i.e. that she is unable to perform any and every duty of any occupation for which she could reasonably be fitted by education, training or experience). If Ms. Parker is successful in doing so the onus shifts to the defendant to prove that there is such a specific occupation that Miss Parker is capable of substantially performing...³⁰

A similar onus appears to have been imposed in the case of *Fulton v. Manufacturers Life Insurance company* where the court said the following:

The evidence does not suggest an employment for which he might be suited in his present condition. The test must be whether it is probable that a reasonable employer would hire Mr. Fulton, either with his present qualifications or those he might reasonably acquire through education or training. Even on the good days, which occur less than half the time, he experiences a degree of pain and cannot sit for long nor remain physically active for long. He must rest frequently. On bad days I am satisfied that he is so consumed by pain he is incapable of gainful activity.³¹

What is misguided about the burden imposed in the *Parker* case is that it requires the insurer to show that there is a specific occupation that the plaintiff could do in his or her *current* condition. Obviously, a plaintiff's ability to work can deteriorate over time for reasons for which an insurer should not be held responsible, e.g., the plaintiff fails to follow his or her doctor's recommendations about exercise and becomes completely deconditioned. Surely, if there is an onus on an insurer to point to a specific occupation the plaintiff could perform, the relevant time period for assessing the plaintiff's condition would be the date the insurer terminated benefits or refused to pay them in the first place.

The test in *Fulton* is even more misguided than the *Parker* test. The *Fulton* "reasonable employer" test not only incorporates the *Parker* problem of assessing the plaintiff's *current* condition, but it renders even that condition potentially irrelevant. The probability of a reasonable employer hiring a person may have absolutely nothing to do with that person's physical or mental condition. Someone who has been out of the workplace for several years, for whatever reason, may not be an attractive candidate for employment. Thus, the *Fulton* "reasonable employer" test appears to have very little to do with the test of total disability under the types of policies we are considering.

³⁰ *Parker v. Saskatchewan Hospital Association*, [2000] I.L.R. 6137 at 6141.

³¹ *Fulton v. Manufacturers Life Insurance Company*, [1990] I.L.R. 10228 at 10237 (N.S.Co. Ct.).

Nonetheless, insurers have tried to satisfy the burden on them as described in cases like *Parker* and *Fulton*. In the *Parker* case, the defendant had a functional capacity evaluation performed upon Miss Parker which indicated, not only that she was capable of sedentary work, but which specifically indicated that she was capable of performing certain jobs such as food tester, quality-control inspector, or quality-control technician-food processing (Miss Parker had been a laboratory technologist). The court dismissed this evidence in one fell swoop with the following reasoning:

If one accepts, however, that Ms. Parker does experience the serious strength, stamina and other limitations which I have found she does...that although she may have or can obtain, through education and training, the skill or technical competence to perform the functions of these proffered occupations that does not establish her ability "to perform any and every duty of the occupation". Pragmatically speaking, an essential duty of any occupation is to provide a level of employment service that meets minimum productivity expectations of an employer....Although such a conclusion conflicts with the results of the physical capacity assessment... it is consistent with some of the subjective factors present as a significant component in the diagnosis of chronic pain syndrome.³²

In the above quotation, the court in *Parker* is accepting the good days-bad days testimony of the plaintiff. The quotation from *Fulton* above is another example of the court accepting the plaintiff's good days-bad days testimony. If a court is inclined to believe such testimony, it is difficult to think of any substantive evidence the insurer could put forward that would make any difference. A functional capacity assessment, which usually lasts from one to three days, can, even if the plaintiff demonstrates a physical capacity to work, be discounted on the basis that two or three good days does not constitute the ability to do regular work day in and day out. Similarly, a few days of surveillance, as substantive evidence, is not likely to rebut a believable rendition of the good days-bad days testimony. The surveillance can be discounted on the basis that the activities the plaintiff engaged in occurred on good days and are not, in any event, equivalent to the stress and rigors of full-time work. Indeed, it is my view, that, once a plaintiff gives the good days-bad days testimony on discovery, it is often a waste of money to conduct a functional capacity or vocational assessment. As *Parker* shows, such assessments, as substantive evidence, are easily discounted by a judge who believes the good days-bad days testimony.

Equally ineffective to substantively rebut the good days-bad days testimony will be any other medical evidence that the insurer can obtain. Given that we are dealing with subjective conditions, the best substantive evidence an independent medical examination will provide is that there is no objective basis for the plaintiff's complaints. The plaintiff may freely admit that the condition or syndrome he or she suffers from is, by definition, one which cannot be tested or diagnosed objectively. Obviously, I am not suggesting that an insurer should go to court without its own medical or vocational evidence. On occasion, a

³² *Supra* note 30 at 6142-43.

functional abilities evaluation or independent medical examination will challenge the plaintiff's credibility by indicating that his or her symptoms are being amplified. Even where this is not the case, a distinguished doctor who performs well on the stand can influence a judge or jury whether or not he or she is really "adding any value" to the plaintiff's self-reports. And, of course, one needs medical experts to give general testimony on the nature of syndromes like fibromyalgia and the likelihood of them being totally disabling. However, if the onus is on the insurer to find a specific job the plaintiff can do, or a specific employer that would hire him or her, then it is submitted that that onus is an impossible one to meet where the plaintiff's testimony has been of the good days-bad days type. And since the law does not impose impossible burdens on a party, the *Parker* or *Fulton* tests cannot be right.

VIII. Credibility

Faced with good days-bad days testimony, the only reasonable burden that can be imposed on the insurer is to cast sufficient doubt on the credibility of that testimony. And it is not reasonable to expect the insurer to be able to "shred" every statement made by the plaintiff, his doctors and the lay witnesses. The obligation is on the plaintiff to make full disclosure of his or her condition. As stated in the case of *Poersch v. Aetna*:

...the insurer and insured also owe a duty of utmost good faith to each other. The reason for this is that the insured alone knows the facts of material importance to the insurer in accepting, assessing, or continuing a risk or assessing and valuing a claim. Since it is difficult or impossible for the insurer to determine these facts, the obligation requires the insured to make full and accurate disclosure to the insurer.³³

If the insurer can show that the plaintiff/insured has not made full and accurate disclosure, either to the insurer or to doctors, the insurer should be taken as having met its onus and should have a legitimate chance of having the plaintiff's claim dismissed. Obviously, the insurer will have to show more than one or two minor inconsistencies in the plaintiff's evidence: it is submitted that the non-disclosures proved by the insurer would have to be significant. The courts must remember the "difficult or impossible" situation insurers find themselves in, as described in the above quotation from *Poersch*. Although cases of fraud do exist, courts should not impose upon the insurer the burden of proving fraud or that the plaintiff was intentionally misleading the insurer or medical professionals. To conclude that a plaintiff's testimony is not credible is not necessarily to conclude that the plaintiff has intentionally misled anyone. Plaintiffs may genuinely believe that they are a lot more limited than they actually are. If that is the case, courts can find their stories to lack credibility without finding any intention to mislead. The burden of proving fraud is, again, a near impossible one and thus an insurer cannot be reasonably expected to meet that burden. It

³³ *Poersch v. Aetna* (2000), 49 C.C.E.L. (2d) 94 at para. 56.

is submitted that Judges have to be willing to find plaintiffs non-credible where they have significantly failed in their duty of full disclosure. And, of course, once a plaintiff is found to lack the requisite credibility, the medical evidence which is based on the plaintiff's self-reports also becomes non-credible. In effect, the medical evidence in a subjective disability case is a house of cards with the credibility of the plaintiff as the foundation. Take the foundation away, and the house of cards crumbles.

In my view, the best way of removing or softening the foundation is with surveillance. I indicated above that, as substantive evidence, surveillance may not be effective to rebut the good days-bad days testimony. However, as evidence going to credibility, surveillance can be a very powerful tool in rendering the plaintiff non-credible and therefore rendering the good days-bad days testimony non-credible. Surveillance is also, perhaps, the best way to deal with the testimony of the plaintiff's lay witnesses. If the testimony of these lay witnesses, as to the plaintiff's level of disability, is contradicted by surveillance, then the bias of the lay witnesses, referred to earlier, has been proved and their testimony should be largely discounted.

I have argued that an insurer should not bear the onus of proving fraud. On the other hand, it is clear that such cases do exist and surveillance is often the tool that reveals them. As stated by Dr. Wolfe:

In recent years I have reviewed many cases in which fine, capable physicians (including rheumatologists) have asserted the patient was entirely well before a traumatic injury. Yet review of records unknown to the physicians indicated the opposite: that the patients had long histories of medical complaints and FM symptoms. I have seen three cases of clear-cut fraud: patients alleging disability were, in fact, entirely well and feigning illness. Surveillance cameras have documented a number of such cases.³⁴

As Dr. Wolfe indicates, fraud exists and courts should be willing to call it when they see it. Significantly, Dr. Wolfe also refers to cases where doctors have made completely inaccurate assertions based on, presumably, what their patient has told them. This, in my view, would be an example of non-disclosure significant enough to render a plaintiff non-credible, whether or not the plaintiff was intentionally trying to mislead his or her doctor.

IX. *Conclusions*

It has been argued above that, as substantive proof relating to subjective disorders is difficult to come by, the onus of proof has played a large role in disability cases. Depending on how the court has been inclined, the onus on the plaintiff has ranged from a requirement to furnish "objective" proof, to an onus met by his or her own perceptions of disability alone. The onus on defendant/

³⁴ Wolfe, *supra* note 19 at 1248.

insurers has varied as well with some courts requiring them to find a specific employer that would hire the insured. I have argued, in this paper, that "proof" in subjective disorder cases boils down to credibility and any "onus" should relate to proving the self-reports credible or non-credible.

Courts are generally reluctant, however, in disability insurance litigation, to dismiss plaintiff's complaints, and actions, for want of credibility. No doubt, there are almost always compassionate grounds to find in favour of the plaintiff. In the *Maleschuk* case, for example, the plaintiff had already declared bankruptcy after losing \$112,000.00 in a failed business venture and, had his story been found non-credible, he would have had to repay the insurer all the benefits he had received from December, 1991 to June, 1996. Other cases cry out even more for judgments in favour of plaintiffs, for example, where the plaintiff has had to go on welfare after the insurer's terminations of benefits or otherwise finds himself or herself in desperate financial straits. Sometimes, plaintiffs' families, including children, would suffer if the plaintiff were denied benefits.

Insurers are not nameless, faceless corporations who are impervious to such circumstances. Real human beings, with families of their own, adjudicate plaintiffs' claims and try to make correct decisions based on all the evidence available. These people, however, perhaps more than judges, are cognizant of the wider ramifications of paying unjustified claims on humanitarian grounds. With hundreds of millions of dollars being paid out in Canada on subjective claims, premiums for the insured are forced to rise dramatically. This, of course, causes some workers to elect not to have long-term disability coverage at all. Obviously, there are compassionate grounds for not wanting such people to become genuinely totally disabled without coverage. So these types of considerations work both ways.

I certainly subscribe to the view that justice must be tempered by mercy. There is a middle ground to be found in most of these cases. It is a common misconception, in disability cases, to believe they are "all or nothing" affairs: either the plaintiff is totally disabled and entitled to everything or he or she does not meet the policy definition and is entitled to nothing. It is open to courts to find the plaintiff entitled to disability benefits for a *certain period only*. This period might be one within which the plaintiff, if serious in his or her attempts to recover, would likely have done so had he or she participated in a proper rehabilitation or work-hardening program. In a recent unreported jury decision in a disability case, the jury awarded disability benefits but only up to the date of the insurer's surveillance which the jury obviously found persuasive.³⁵ These "periods" of disability which may be awarded by the Court can still be substantial enough to get the plaintiff back on his or her feet without putting the insurer in the perhaps unjustified situation of having to foot the full bill in a dubious case.

³⁵ *Doran v. Canada Life*, unreported jury decision.

Alternatively, courts in these cases could give more weight to the doctrine of mitigation and find that the plaintiff's damages should be reduced somewhat for failure to mitigate. The subject of mitigation in disability cases is the topic for another paper, but it is clear that the doctrine applies in disability cases and, in my view, has been largely and unjustifiably discounted.

Certainly, in my practice, I do not treat these cases as "all or nothing" cases. And it is not just me. Disability insurers, from my experience, are almost always willing to seek a compromise but it must be one by which the plaintiff takes some deduction for the evidence that the insurer has, particularly the evidence that tends to undermine the plaintiff's credibility. In today's world of aggravated and punitive damages, coupled with a climate where courts, in my view, are not giving sufficient weight to the credibility issues raised by the insurers, plaintiffs are becoming more aggressive and less willing to compromise their claims. Disability insurers now regularly face the situation where a plaintiff will refuse an offer of complete reinstatement of benefits plus interest and costs because he or she is holding out for something for aggravated or punitive damages.

No one should shed any tears for insurers because of all of this. However, they are as entitled as plaintiffs to justice and, in my view, that will be achieved if the evidentiary burden on them in subjective cases is one which requires them to prove significant non-disclosures by the plaintiff and/or significant inconsistencies in the plaintiff's evidence. Indeed, once it is realized that these subjective disability claims revolve around the issue of credibility, we can drop all reference to the issue of onus of proof and simply focus on whether or not the plaintiff's self-description of his or her symptoms and limitations is credible. If a plaintiff's story suffers from no significant inconsistencies, the plaintiff will be entitled to retroactive unpaid benefits and a declaration of disability. If the insurer can poke significant holes into the plaintiff's story, the plaintiff's damages should be reduced or, if the holes are significant enough, the plaintiff's case should be dismissed. Although this situation can be characterized in terms of certain evidentiary burdens that the parties have to meet, there is no necessity that it be so characterized. Getting rid of all this talk of onus of proof will save the court time spent arguing the issue, and the paper and judges' time needed to consider the arguments. The issue of onus of proof need rear its head no more in disability cases than in any other civil case.