IN THE MATTER OF AN ARBITRATION

(Under the Ontario *Labour Relations Act, 1995*)

BETWEEN:

HAMILTON HEALTH SCIENCES

(the "Hospital")

-AND-

ONTARIO NURSES' ASSOCIATION

(the "Union")

AND IN THE MATTER OF the arbitration of policy grievances concerning the administration of the sick leave benefits plan under the collective agreement between the parties.

BEFORE: G. T. SURDYKOWSKI – Sole Arbitrator

APPEARANCES:

For the Hospital: Mark Zega, Counsel; Jane Gooding, Counsel; Cristina Vallonio, Labour Relations Analyst; Colleen Lynas, Labour Relations Associate; Kelly Corp, Mgr. Health, Safety and Wellness; Mary Gingrich, Disability Associate; Meaghan Hastie, Analyst (Attendance).

For the Union: Kate Hughes, Counsel; Nicole Butt, ONA Counsel; Colleen Ionson, Labour Relations Officer, Pat MacDonald, Bargaining Unit President and Local Coordinator; Connie Ross, Local VP and Grievance Chair; B.J. Swanson, Henderson Site Rep.; Cynthia Mascoll, Chedoke Site Rep.; Gail Molnar, MUNC Site Rep.

HEARINGS HELD IN HAMILTON, ONTARIO ON JANUARY 17 APRIL 27, 28, MAY 8, 9, 24, DECEMBER 13, 14 AND 18, 2006, AND JANUARY 31, FEBRUARY 1, 2, 7, 9, 13, 16, 20, MARCH 6, AUGUST 22, 23, 2007.

Copyright © George T. Surdykowski Arbitration/Mediation Inc. 2007

[All rights reserved. Reproduction in whole or in part, in any form or format, by anyone other than the parties, or for use in legal proceedings, for not-for-profit educational purposes, or as required or permitted by law, without express written consent is prohibited.]

AWARD #1
"MEDICAL CERTIFICATE OF DISABILITY" FORM ISSUE

I. INTRODUCTION

1. This proceeding concerns two policy grievances. It has been bifurcated into three phases. The Award numbers reflect the phase that the particular Award relates to. I have previously issued Awards #1A (dealing with a preliminary issue in Phase #1) and #2 (dealing with an *Employment Standards Act* issue in Phase #2). This Award deals with the Union's allegation in Phase #1 that the "Medical Certificate of Disability" application form for short term sick leave benefits that employees are required to submit is improper. Although the issue is restricted to the short term disability ("STD") requirements it encroaches upon return to work issues.

2. Paragraphs 1-14 of the Introduction in "Award #1A – "Preliminary" Issue" are an equally appropriate general introduction to this Award.

3. However, it bears repeating that prior to the spring of 2005 the Hospital's Employee Health Services ("EHS") Department processed sick leave benefits applications, and obtained information from employees for that purpose. EHS assessed or "adjudicated" employee applications for sick leave benefits and determined in each case whether the employee was entitled to sick benefits. EHS also sought to facilitate early and safe returns to work, with necessary accommodations as required. Although there were (and are) confidentiality protections in place, EHS had to share certain limited information regarding employees' medical conditions with Hospital management in order to perform this function (see Appendix "AA" and paragraph 53, below).

4. The Hospital decided to outsource the short term disability ("STD") sick leave benefit application and assessment/adjudication function for operations and efficiency reasons. Cowan Wright Beauchamp ("Cowan") was the successful private sector bidder for this contract and took on the role and functions formerly performed by EHS, beginning on April 4, 2005 at the General

site, April 25, 2005 at the McMaster site, May 16, 2005 at the Henderson site, and June 6, 2005 at the Chedoke site. The contract between the Hospital and Cowan in that respect (Exhibit #18 – the "Cowan contract") as produced, with financial details deleted as confidential and irrelevant and with emphasis added, is attached as Appendix "C" to this Award. I have included it in this Award for the sake of completeness notwithstanding that this contract does nothing to resolve the matters in issue. A contract between the Hospital and a third party cannot give the third party any greater rights than the Hospital itself has with respect to bargaining unit employees.

5. The "Medical Certificate of Disability" (hereinafter referred to as the "Cowan form"), that Cowan requires all employees who apply for sick leave benefits to complete was entered into evidence as Exhibit #22. It is reproduced as Appendix "A" to this Award. The evidence includes three versions of the "Attending Physician's Statement" that the Hospital's EHS Department used over the years for that purpose before the Hospital contracted that function out to Cowan. On the face of these documents the most recent of these was "updated" in November 2002. For the purposes of this case, these appear to be substantially the same and I include only the most recent one as Appendix "AA" for comparison purposes.

6. The Union alleges that bargaining unit nurses are being told that they must sign the consent in the Cowan form and provide all of the information requested, and that they will be denied benefits if they do not do so. The Union asserts that the consent being required of employees in Section B of the Cowan form is coerced, and is therefore not a true consent, and that the consent being required is in any event too broad or otherwise improper. The Union also objects to the reference in Section B of the Cowan form to a maximum reimbursement of $35.00 to the medical professional who completes the form. The Union alleges that Section C of the Cowan form requires employees to disclose confidential personal medical information that goes beyond what is necessary or appropriate for short term sickness benefits purposes, and which violates bargaining unit employees' collective agreement and statutory privacy rights.

7. The Union does not object to the use of a consent and medical information form for the purpose of STD benefits under the collective agreement. It recognizes that the Hospital is entitled to information in that respect. The Union's concern is with the manner and scope of the consent,

and the nature and extent of the confidential medical information that the Cowan form requires bargaining unit employees to provide. The issue in this case is not the extent of the consent or medical information that the Hospital can legitimately seek and use in any particular individual case. The Union acknowledges that a more intrusive investigation of the basis for an application for STD benefits may be appropriate in a particular individual case. The issue is the more general one: that is, what consent and medical information can the Hospital require every employee who seeks STD benefits to provide as a matter of course in the first instance, failing which benefits will be denied? That is an issue which is appropriately raised in a policy grievance, which is what I have before me.

8. In addition to *vive voce* evidence, I have been provided with hundreds of pages of documentary evidence. Counsel made oral and written submissions, and filed numerous (48) Court and arbitration decisions in aid of their submissions. I find it unnecessary to review the evidence in detail, or to set out the parties' submissions even in summary form. I have reviewed the collective agreement, the legislation cited to me, and the evidence. I have read all of the authorities filed, and considered the oral and written submissions. Many of the authorities are of little or no real assistance, and I do not consider it necessary to analyze or even list them. I will address the evidence and arguments, and refer to the jurisprudence as I consider appropriate. I note that unless a different analysis in another jurisdiction is particularly persuasive, I consider it appropriate to give greater weight to the jurisprudence in the jurisdiction in which the case at hand is being litigated when there is a divergence of jurisprudential opinion between jurisdictions, and that is what I have done.

9. I note that there are other separately represented bargaining units at the Hospital. I understand that the Hospital uses the same Cowan form and services for all of them. During argument in Phase 3 of the proceeding (i.e. after Phases 1 and 2 had been completed and while I was in the process of preparing this Award) an award dated July 10, 2007 issued by Arbitrator Knopf with respect to a dispute between the Canadian Union of Public Employees and the Hospital concerning the Cowan form and Cowan's conduct was brought to my attention. The Knopf Award in the "CUPE case" arises out of a mediation/arbitration proceeding held the same day as that award was issued and concerns a different collective agreement bargaining relationship. It is

neither binding on me, nor of any particular assistance. However, I was referred to it and I am constrained to comment on it in due course, below.

II. COWAN'S EXPLANATION OF ITS FORM

10. As noted above, the Cowan form is reproduced as Appendix "A" to this Award. Exhibit #45 is typical of the letter that is being sent to employees who seek STD benefits. It reads (with dates deleted as irrelevant and as having the potential to identify the employee to whom the particular letter was sent) as follows:

> As you are aware, the hospital has implemented a new process for Short Term Disability adjudication.
>
> We have determined that the Medical Certificate of Disability will be considered the satisfactory proof of disability that we require to justify absences from the workplace as outlined in the Hospitals of Ontario Disability Income Plan (1992). This will be required for all absences of 5 shifts or greater. Cowan Wright Beauchamp, will act on behalf of the hospital to review and assess this information, in consultation with the Family Physician, and advise if there is medical to support the absence. This information will be held in the strictest confidence with Cowan Wright Beauchamp, and no information with respect to diagnosis will be shared with any Hamilton Health Sciences employee, without the expressed consent of the individual employee in question.
>
> If employees do not consent to providing the Medical Certificate of Disability to the appropriate Health Professional, then we will not be able to establish if proof of disability has been met, and as a result, the employee will not be paid sick pay benefits.
>
> You have been absent as of ___ and at this time you still remain off. You will need to provide medical documentation to support that absence. Enclosed you will find a letter for your doctor explaining the process and a Medical Certificate of Disability which your doctor will need to complete. There is a star on that form where you will, need to sign your consent. Please ensure that Cowan Wright Beauchamp receives the required documentation to support your absence by ____. If you are unable to provide this documentation, we will not be able to adjudicate your claim, sick pay benefits may not be in order, and an overpayment recovery would have to be set up.
>
> Enclosed is a copy of the brochure, which was attached to your pay stub on _____, which explains and outlines the process. Also enclosed is a copy of the Attending Physician Statement that is required under this process. If you have any questions or concerns about this process please contact ...
>
> (Emphasis added.)

11. Also in evidence as Exhibit #9, and reproduced as Appendix "B" to this Award, is the "Functional Abilities Form" ("FAF") that the Hospital is using for the purpose assessing employees when they are ready to return to work from an illness or injury. It is useful to compare the Cowan form to this FAF as well as the Attending Physician's Statement previously used by EHS.

12. Helene Santerre is the Cowan representative who drafted the Cowan form in issue, which she customized for the Hospital's use. She does not deal with the Cowan form on a day-to-day basis but continues to have oversight responsibility for it. Santerre testified that Cowan's role in the process is to provide sick leave adjudication and to ensure that employees who apply for short term sick leave benefits obtain appropriate treatment. She says that Cowan can facilitate medical testing and specialist consultations, and provide support to employees and facilitate their return to work. Although Santerre testified that all of the Cowan employees who perform these various functions are medical health professionals it is clear that that is not the case. On the face of its proposal to the Hospital at least one Cowan employee (Geil) was not a medical health professional even then, and another non-medical health professional (Higgenbotham) subsequently became directly involved. Cowan also seeks to identify sick claim trends with a view to reducing these through wellness programs. Santerre confirms that Cowan's role is to report on the status and make recommendations about sick benefits claims, and that the Hospital has the final say in that respect.

13. Santerre testified in examination-in-chief that when she was drafting the form she looked at the 1980 and 1992 HOODIPs, the Hospital's existing policies and the collective agreement. However, she says that she did not look at the collective agreement to ensure that the Cowan form was consistent with it. Indeed when asked in cross-examination whether she (or Cowan) reviewed the collective agreement (which include the 1980 and 1992 HOODIPs) in order to ensure that the Cowan form is consistent with it Santerre responded that "we were not asked to do that", which I take to mean that neither she nor anyone else did so. On the evidence, it is hard to believe that Santerre, who conceded in cross-examination that she did not review either HOODIP when she drafted the Cowan form, or anyone else at Cowan paid any attention to the collective agreement.

14. Santerre also appears not to understand the HOODIP definitions of "total disability" or "totally disabled". Santerre testified that impairment does not equate to total disability and the Cowan materials (specifically Exhibit #20) refer to an employee's inability to perform the "essential" duties of her occupation, but both HOODIPs define the eligibility as the inability to perform the "regular" duties of the employee's occupation. While Santerre's broad general statement that a person whose abilities are impaired may not be totally or at all disabled is accurate as far as it goes, her example of someone with a broken leg still being able to perform reception work and her assertion that an impairment does not necessarily mean that bargaining unit nurse cannot perform any of her normal duties demonstrate that Cowan does not appreciate the distinction between essential and regular duties for STD benefits purposes under the HOODIPs, particularly when it comes to nurses. There is a difference between essential and regular duties. As a general matter regular duties is a broader category which encompasses but is not limited to essential duties. Nor is it clear that Santerre appreciates that the Hospital is a highly unionized environment because even if an ill or injured nurse could be assigned to clerical or non-nursing duties doing so could take her out of the bargaining unit and conflict with the rights of employees in another bargaining unit. Perhaps this is why the Hospital has effectively retained full control of return to work and accommodation issues.

15. Santerre says that the Cowan form is similar to (which I take to mean substantially the same as) forms used by other insurers including Sun Life, Great-West Life and Manulife use for the same purpose. (I note that a Manulife medical release form is in evidence (as Exhibit #30), but I did not allow the Hospital to adduce examples of Sun Life or Great-West Life forms because they had not been produced in accordance with my production orders. In any event, the mere fact that an industry norm has developed does not necessarily mean that the practice is acceptable.) Santerre identified three uses for the information obtained from the Cowan form: to determine the applicant employee's eligibility for STD benefits, to ensure that the employee receives proper treatment, and to identify a return to work date and options. She testified that Cowan uses the applicable HOODIP parameters to assess an employee's eligibility for STD benefits. It appears from her testimony that her focus in that respect was on the 1992 HOODIP, which is quite different from the 1980 HOODIP that applies to many of the bargaining unit nurses (see paragraphs 52 and 56-62, below).

16. The Union does not object to the personal information sought in Section A of the Cowan form. Section B is the consent to release information part of the form. The Hospital's Attendance Awareness Program document (Exhibit #41) speaks in terms of employees providing "appropriate" consents to the release of medical information sufficient to allow the Hospital to fulfill its responsibilities. Santerre testified that the purpose of Section B is to inform the employee of the information that is being requested and that more may be requested, of what Cowan will be doing with the information, and to preserve the confidentiality of the information. She explained that Cowan only wants information that is "relative" to the absence in issue, that Cowan seeks "restrictions or limitations" information for return to work purposes, notwithstanding that she is aware that the Hospital has a separate return to work information form (i.e. the FAF) and process. Santerre says that Cowan seeks a release for "WSIB" information so that it can coordinate return to work efforts with that agency, and for an "Automobile insurer" [sic] because such an insurer is the "first payer" if a claim arises out of a motor vehicle accident. She says that return to work information may be shared with supervisors, and "when applicable" the WSIB, an automobile insurer and the long-term disability insurer. Finally, Cowan decided to include the reference to maximum reimbursement of $35.00 for completing the form, which Santerre says is in accordance with OMA and CMA guidelines, so that the doctor will know that he will be reimbursed in that amount and be aware that the employee will be responsible for any amount in excess of that. This is another illustration of Cowan's failure to review the collective agreement and ensure that the Cowan form complies with it. Article 12.14 of the Central portion of the agreement clearly specifies that the Hospital is responsible for the full cost of any medical certificate that is required of an employee.

17. With respect to Section C, Santerre testified that requests for diagnoses are "normal in the field". Although she agreed in cross-examination that Cowan doesn't necessarily need to have diagnosis, treatment or medication information to verify STD benefits eligibility and that an employer only needs to know an employee's functional limitations, not the diagnosis (which she says is not communicated to the Hospital in any event), Santerre nevertheless maintained that Cowan requires the primary diagnosis and symptoms in order to perform its adjudication function. She says the primary diagnosis and symptoms reveal the nature of the illness and permits Cowan

to assess the reasonableness of the duration of the absence. It is difficult to reconcile Santerre's assertion that Cowan requires diagnosis and symptoms information to perform its adjudicative function and to assess the reasonableness of the duration of the absence with her need to know admissions in cross-examination. Not only did she agree with Union counsel that Cowan doesn't necessarily require diagnosis, treatment or medication information in order to verify (which I consider indistinguishable from adjudicate) STD benefits eligibility, she frankly acknowledged that an employer does not require diagnosis information. If the employer, in this case the Hospital, does not require the information, it is not entitled to it unless the collective agreement so provides (an issue that I will return to below). Since a third party agent like Cowan stands in the shoes of the Hospital neither is it entitled to it. Notwithstanding this, Santerre maintained that such information, "current findings" and a prognosis are "useful" for return to work purposes and to assess the appropriateness of the treatment, which Santerre was quick to say was not for the purpose of questioning the doctor but to permit Cowan to facilitate or make treatment suggestions. Santerre says that Cowan seeks a secondary diagnosis and symptoms because that could be what is preventing the employee from returning to work. In cross-examination, Santerre agreed that the Section C information is unnecessary because of the Hospital's own FAF return to work form and process, but she continued to insist that Cowan nevertheless requires that information in order to provide disability management and to facilitate and assist in the employee's medical treatment. Indeed, Santerre testified in cross-examination that the focus of Section C is on return to work issues, and agreed that the Hospital's own FAF provides all of the return to work information that an employer needs. It is clear from the evidence that the Hospital maintains complete control over all aspects of the return to work and accommodation process notwithstanding the provisions in its contract with Cowan in that respect.

18. Santerre explained that the attending physician is in the best position to assess an employee's medical status, and that the physician's role is to diagnose and treat the employee, and provide functional abilities information, but not to determine whether the employee is totally disabled for employment and benefits purposes. In cross-examination, Santerre agreed that the attending physician would be in a better position to do so if s/he were provided with a job description and demands analysis (which the Hospital has for all bargaining unit positions), but she also said that doctors have a limited amount of time to spend on these issues and often are not used

to or comfortable dealing with them. Santerre says that Cowan's role is to adjudicate the claim for benefits, to ensure that the employee is receiving appropriate treatment, and to discern return to work options. It appears from Santerre's evidence that Cowan is seeking the type and amount of confidential medical information because its view is that a bargaining unit nurse is not totally disabled for STD benefits purposes if she can do the essential or perhaps even any of her normal duties. This is the wrong test under either of the HOODIPs (see paragraph 52, below)

III. WHAT CONFIDENTIAL MEDICAL INFORMATION CAN AN EMPLOYER REQUIRE

General Principles

19. At least two questions typically arise in medical information cases: what is appropriate as a matter of general practice and policy, and what is appropriate in a particular case? These grievances directly raise the general practice and policy issue. But they also engage the question of the particular case as the counterpoint. That is, a question that arises is whether the sort of invasive inquiry that may be appropriate in a particular individual case is also appropriate in the first instance in every case.

20. Both subjectively and objectively, personal medical information is confidential personal information. The confidentiality of the doctor/patient relationship and personal medical information is universally and legislatively recognized as one of the most significant privacy rights in modern Canadian society. There appears to be a general societal notion that the right to privacy is a basic human right, particularly in a modern democratic society. But employer and employee rights in that respect do not arise out of the air. It is far from clear that there is a common law right to privacy (although there is some American jurisprudence that seems to suggest there is – see, for example, *Holloman v. Life Ins. Co. of Virginia*, 192 S.C. 454, 7 S.E. 2d 169, 127 A.L.R. 110), but I think it unnecessary to digress into that discussion (particularly when the parties did not do so). Although the right to privacy is not a right listed in the *Canadian Charter of Rights and Freedoms* or the *Human Rights Code*, there is privacy protection legislation that addresses and reflects the

prevailing societal notions of privacy rights with respect to personal health information. This legislation "occupies the field" and overtakes any common law notion of a right to privacy. The *Personal Health Information Protection Act, 2004* (the "PHIPA"; see Appendix "D", attached) is a comprehensive piece of health care privacy legislation. The *Occupational Health and Safety Act* (the "OHSA") contains a medical information privacy provision which prevails over the PHIPA (section 63(6); see Appendix "E", attached).

21. There is nothing in the mere existence of an employment relationship that gives the employer any inherent right to compel its employees to compromise their legitimate right to keep personal medical information confidential. An employer only has a right to an employee's confidential medical information to the extent that legislation or a collective agreement or other contract of employment specifically so provides, or that is demonstrably required and permitted by law for the particular purpose. Except where required or permitted by law an employer cannot seek and a doctor cannot give out <u>any</u> patient medical information without the patient's freely given informed specific authorization and consent. But there are few if any things that are confidential for all purposes or in all circumstances and the privacy right that attaches to confidential medical information is not absolute. The dispute between the parties reveals the tension between an employer's right to or legitimate need for information in order to properly manage its business and the workplace, and to meet its statutory and collective agreement obligations, and an employee's right to personal privacy.

22. The law that applies to privacy issues includes the "law" that the parties to a collective agreement of individual contract of employment create for themselves. Of course this party created law must fit within the mandatory parameters created by legislation. There is some legislation that parties cannot contract out of (the *Labour Relations Act, 1995* and the *Employment Standards Act*, for example), and there is legislation that the parties can contract out of (the *Arbitration Act*, for example). Parties cannot contract out of the PHIPA or the OHSA.

23. Most modern collective agreements contain sick leave benefit provisions. A fundamental principle that underlies every collective agreement is that bargaining unit employees are under an obligation to regularly attend work as scheduled in accordance with the collective agreement, and

to provide notice of and a legitimate excuse for absences from work. Employees are entitled to be paid for work performed in accordance with the collective agreement. In the absence of collective agreement provisions employees are not entitled to be paid if they do not attend work. Employer paid leave benefits, including STD benefits, are all contractual. Paid leaves of absence, whether the absence is due to illness or injury, or otherwise are only available to the extent that the collective agreement so provides, and then only on the negotiated terms that the agreement stipulates.

24. The onus is on the employee to establish entitlement to collective agreement paid sick leave benefits. This generally means that the onus is on the employee to establish that an absence is legitimate in the sense that she is genuinely unable to report for work due to illness or injury. As a general matter, the employer is entitled to sufficient "proof" of the employee's assertion that she is unable to attend work due to illness or injury and entitled to benefits. Also as a general matter, even if there are no paid benefits available, or the employee elects to forgo them, the employer is entitled to notice of the fact and expected duration of an absence for the legitimate business purposes of work force management and absenteeism control purposes. Both the employee and the employer have a legitimate interest in and an obligation to facilitate as early a return to work as possible, with accommodation as appropriate where reasonably available. The employer also has a legitimate interest in investigating suspicious absences and information provided by an employee in that respect. Of course all of this begs the question: what is sufficient "proof" in that respect? What information is the employer entitled to and what information must the employee provide?

25. As a matter of general principle in that latter respect, what is required is sufficient reliable information to satisfy a reasonable objective employer that the employee was in fact absent from work due to illness or injury, and to any benefits claimed (see, Arbitrator Swan's comments in *Re St. Jean De Brebeuf Hospital and C.U.P.E., Loc. 1101*, (1977) 16 L.A.C. (2d) 199 at pp. 204-206). As a general matter, the least intrusive non-punitive interpretive approach that balances the legitimate business interests of the employer and the privacy interests of the employee is appropriate. But what the employer is entitled to, and concomitantly what the employee is required to provide, will first and foremost depend on what the collective agreement or legislation provide in that respect.

26. I note that the privacy legislation provision is written to require that (subject to exceptions stipulated) the person concerned is the one who must provide an appropriate consent to the disclosure of her confidential medical information. This does not necessarily mean that the person concerned is the only one who can consent to the release of confidential personal medical information for the purpose of establishing the *bona fides* of an absence form work or an entitlement to paid benefits in that respect. In this jurisdiction a union which holds bargaining rights for a bargaining unit of employees has the exclusive right to represent those employees in all employment related matters. An employee cannot bargain directly with her employer in that respect. Indeed, it is an unfair labour practice for an employer and an employee to bargain directly with respect to any term, condition or other matter related to the employee's employment in the bargaining unit (sections 70 and 73 of the *Labour Relations Act, 1995*). Accordingly, the Union is entitled to negotiate both collective agreement benefits entitlements and the preconditions to such entitlements, including the information that must be provided in order to obtain a particular benefit. That is, as the exclusive bargaining agent the Union can effectively consent to the release of the confidential personal medical information that is required in order to establish entitlement to an STD benefit payment on behalf of bargaining unit employees (subject of course to a bargaining unit employee declining available STD benefits).

27. The several layers of legitimate employer interests suggest that there is more than one stage to the process that is engaged when an employee seeks the benefit of the sick leave provisions in a collective agreement. It also suggests that the employer will generally be entitled to less information at the initial stage than at a subsequent stage. The employer's desire for more information, or its genuine concern for an employee's well-being or desire to assist the employee, do not trump the employee's privacy rights. Nor do questions of expediency or efficiency. In the absence of a collective agreement provision or legislation that provides otherwise the employer is entitled to know only that the employee is unable to work because she is ill or injured, the expected return to work date, and what work the employee can or cannot do. A document in which a qualified medical doctor certifies that an employee is away from and unable to work for a specified period due to illness or injury is *prima facie* proof sufficient to justify the absence. Unless the collective agreement (or less likely, legislation) stipulates otherwise, it will also be sufficient to

sufficient to qualify the employee for any applicable sick benefits for that period. To require more invites an unnecessary invasion of the employee's privacy. In order to obtain additional confidential medical information, the employer must demonstrate a legitimate need for specific information on an individual case-by-case basis. That is, for sick benefits purposes an employer has no *prima facie* right to an employee's general medical history, a diagnosis, a treatment plan, or a prognosis other than the expected date that the employee will be able to return to work with or without restrictions.

28. As a general matter there is nothing to prevent an employer from contracting out the information gathering or assessment of medical information function, as the Hospital has done in this case. But the party to whom the employer has contracted out this function stands in the shoes of the employer and has no greater right to or need for information than the employer has if it performs the function itself. And the employer is responsible for the conduct of any third party that performs such a function for it. However, the insertion of such a third party, which is a stranger to the workplace and beyond the direct reach of the collective agreement, may raise suspicions and increase an employee's reluctance to provide confidential personal medical information.

29. A diagnosis or statement of the nature of an illness is undoubtedly confidential medical information. There is a broad and consistent arbitral and judicial consensus that in the absence of contractual provision binding on the employee an employer has no right to a diagnosis. I agree. The British Columbia jurisprudence draws a distinction between a "diagnosis" and a statement of the "nature of the illness". Is there a meaningful distinction between "diagnosis" and "nature of the illness" such that an employer is entitled to the latter in the first instance?

30. Santerre testified that the "primary diagnosis and symptoms" requirement reveals the nature of the illness. That is undoubtedly so, but is the reverse is not necessarily the case. *Taber's Cyclopedic Medical Dictionary* defines "diagnosis" as "the term denoting the name of the disease or syndrome a person has or is believed to have" based on medical tests or an examination of symptoms. That is, a diagnosis is a formal statement that specifically identifies a disease or injury based upon an application of medical scientific methods. It is a medical conclusion that is the

product of a process of identifying or determining the nature and cause of an illness or injury from an examination and evaluation of the patient. There are many kinds of "symptoms" (e.g. objective, subjective, cardinal and constitutional), but the term generally refers to any perceptible change in the body or its functions which indicates disease or injury. "Nature of illness" is not a medical term. Having an "illness" or "injury" is the state of being sick or injured, as the case may be. In this context "nature" refers to the kind, class or essential qualities of a disease or injury. Accordingly, "nature of the illness" (or injury) suggests a general statement of a person's illness or injury in plain language without any technical medical details, including diagnosis or symptoms. Although revealing the nature of an illness may suggest the diagnosis, it will not necessarily do so. "Nature of illness" and "diagnosis" are not congruent terms. For example, a statement that a person has a cardiac or abdominal condition or that she has undergone surgery in that respect reveals the essence of the situation without revealing a diagnosis. Once again, what information the employer (or its agent) is entitled to in that respect beyond that described in paragraphs 24 and 27, above, is a matter of contract and legislation.

31. The 1980 HOODIP refers to a proof of disability "such as a doctor's certificate" (see paragraph 52, below). A "certificate" is a document that testifies to the truth of something. For example, a birth certificate testifies to a person's birth name, sex, and the date and location of birth; a marriage certificate testifies to the fact and *prima facie* legality of a marriage; and so on. A certificate from a qualified medical health professional testifies that s/he has assessed a person as being incapable of working at her occupation due to illness or injury for a specified period and constitutes *prima facie* proof of those facts. I agree with the thrust of the British Columbia jurisprudence that it is not inordinately invasive for an employer to ask that a medical certificate include the reason for incapacity, which would appropriately consist of a general statement of the nature of the disabling illness or injury, without diagnosis or symptoms. It is not unreasonable for an employer to require an employee to provide the reason for her absence or claim for STD benefits, and the mere fact that providing that reason (i.e. the nature of her illness or injury) may suggest a diagnosis does not excuse the employee from providing the reason in order to satisfy the onus on her to justify her absence and claim for benefits even in the first instance.

32. But in the absence of a statutory or collective agreement requirement, a diagnosis or description of symptoms or treatment goes beyond the certification of illness or incapacity that is legitimately required in the first instance. It is only where the employer has a statutory or collective agreement right to more information, or where the employer has reasonable cause to suspect the genuineness, accuracy or quality of the information provided to substantiate an absence that it is entitled to additional information. For example, if the employer has an objective reason to doubt that the doctor who signed a medical certificate actually saw or made any professional evaluation of the employee or that the doctor was qualified to provide the assessment in the certificate, or suspects that the employee had gone "doctor shopping", or has information that casts doubt on the *bona fides* of the alleged illness or injury that the employer is entitled to seek additional information that is specific to and reasonably necessary to address its concerns (see, for example, *Re York County Hospital and S.E.I.U., Loc. 204*, (1992) 25 L.A.C. (4th) 189 (Fisher, Chair) at page 193). But these are issues that can arise in individual cases, and is not the more general first instance issue before me in these policy grievances.

33. The issue in this case concerns the extent of the confidential medical information that the employer can require an employee to provide in the first instance. This subsumes the consent issue because the employer cannot require the employee to consent to a release of more confidential personal medical information than it is entitled to for sick leave justification or benefits purposes. The employer can always ask an employee if she is willing to volunteer more information than the employer is actually entitled to, but an employer cannot coerce an employee into "consenting" to provide broader disclosure, and is not entitled to take disciplinary or other steps against, or deny sick benefits to, an employee who declines to provide more medical information than the employer is entitled to. An employer cannot require an employee to consent to a release of more confidential medical information than is permitted or required by statute or the collective agreement, and that is demonstrably necessary for the particular purpose.

34. Further, the intensely personal nature of confidential medical information, the individual, societal and institutional interests in preserving the confidentiality of such information, and the protections that have been legislated to protect its privacy and use, suggest a conservative approach. Accordingly, collective agreement provisions that speak to the information that an

employee must provide to the employer in order to satisfy the employee's obligation to justify an absence or to obtain STD benefits in that respect should be strictly construed.

35. In the first instance for STD benefits purposes, therefore, in the absence of statutory or collective agreement authorization an employer cannot require an employee to consent to the release of more than certification that she is absent and unable to work because she is ill or injured, the general nature of the illness or injury, that the employee has and is following a treatment plan (but not the plan itself), the expected return to work date, and what work the employee can or cannot do. The consent must be both focused on the particular purpose and limited to the particular medical professional. A consent that must be provided for the purpose of STD benefits should not include return to work accommodation considerations other than whether there are likely to be any restrictions on the anticipated return to work date. A "basket" consent that purports to authorize anyone who the employer may ask to release confidential medical information is not appropriate. Nor is it appropriate to require an employee to sign a forward-looking consent that may exclude her from the confidential medical information loop. The overwhelming weight of the arbitral jurisprudence takes a dim view of consents that purport to give an employer prospective permission, particularly where the consent purports to permit the employer to unilaterally (with or without notice to the employee) initiate direct contact with a doctor or other custodian of confidential medical information. Every contact should be through or at the very least with the knowledge and consent of the employee, a separate consent should be required for every contact, and every consent should be limited to the completion of the appropriate form or the specific information required, as appropriate.

36. In the absence of collective agreement authorization a "one size fits all" medical certificate of disability form for STD benefits purposes will necessarily be limited in scope in the first instance. Such a consent should identify the medical professional or custodian of medical information, specify the period it relates to, and although it can ask, the employer cannot require an employee to consent to a release of the employee's general medical history, a primary or secondary diagnosis, a treatment plan (as distinct from the fact that there is one and that it is being followed), or any medical prognosis other than an expected return to work date.

37. What an employer can require of an employee should not be mixed into the same form or same section of the form as what it can ask an employee to volunteer. If a single form is used, it must clearly distinguish between what information is required (i.e. what the employer or its agent is entitled to) and what the employee is being asked to volunteer (i.e. what information the employer or its agent would like to have if the employee is willing to allow the employer to access).

38. An assertion or undertaking to treat all medical information received in a highly confidential manner, and disseminating it solely on a "need to know" basis, alters none of this. It does not expand an employer's entitlement to information, and really adds nothing to the equation since the employer is under such an obligation in any event. Nor does the fact that an employee has a continuing obligation to account for her absence and the employer has a concomitant right of continuing inquiry in that respect alter the analysis. The nature, extent and frequency of an employer's requests for continuing information, from either the employee or medical professionals must be reasonable in the circumstances (and is an issue addressed in Phase 3 of this proceeding). The fact that a new focused consent is required every time an employer seeks to acquire confidential medical information from someone other than the employee may appear to be inconvenient or inefficient, but convenience or efficacy do not modify an employee's privacy rights. This approach will also both encourage the employer to act reasonably and with due consideration of what it really requires for the particular purpose, and offer some comfort to an employee who may already be feeling vulnerable and exposed.

The CUPE Case

39. The text of the Knopf Award in the CUPE case is two single-spaced pages long. It reveals that a mediation/arbitration process was engaged to address "numerous" group and policy grievances challenging the Hospital's use of Cowan to adjudicate benefits claims under the CUPE collective agreement, and the Cowan form and conduct in that respect. The evidence before Arbitrator Knopf was that Cowan's employees are governed by their professional obligations under the *Regulated Health Professionals Act*. That is not the case for the all of the Cowan employees who deal with ONA bargaining unit nurses. The evidence before me is that at least two

of these Cowan employees are not medical health professionals (see paragraph 12, above). The Knopf Award indicates that CUPE raised concerns about the text and content of the Cowan "Medical Certificate of Disability" (i.e. the Cowan Form). Except for the treatment of the doctor's fee for completing the form, these concerns are not specified, and the extent to which the arbitrator considered the concerns to be valid must be gleaned form the amended form that is Appendix "B" to the Knopf Award. A "Required Accommodation Form" was also in issue in the CUPE case. There is an identical such form in evidence before me (Exhibit #24) but the parties paid scant attention to it in the hearing. Their focus was on the Cowan form and the Hospital's own FAF. In any case, it appears that the arbitrator's statement that she was satisfied that the content and treatment of "this form" comply with all statutory requirements and do not violate the CUPE collective agreement refers to this Required Accommodation Form and not to Cowan form that is the focus of this proceeding. Because she does not provide any basis for her conclusion, I cannot tell from her award whether the arbitrator was "satisfied" on the basis of her independent assessment or because the parties came to an agreement in that respect through the mediation part of the process. Since it is unlikely that a one-day mediation/arbitration process presented a full adjudication opportunity in that respect I think that the latter is more likely the case. For policy and practical reasons labour arbitrators are generally willing accept whatever agreements the parties can come to, and unless there is an obvious legal problem are generally "satisfied" that the parties' agreement is statutory and collective agreement compliant. Further, the excerpts from the CUPE collective agreement that are appended to the Knopf Award reveal that only the 1992 HOODIP applies to the CUPE bargaining unit. There are significant differences between the 1980 and 1992 HOODIPs which are important in the case before me. For all of these reasons the Knopf Award is of limited assistance.

A Reality Check

40. I recognize that the real world is not an ideal one. In the ideal world doctors would have perfect knowledge of the relevant medical matters, their patients and their patients' workplaces, and would be completely objective. If that were so, a doctor's simple statement certifying that an employee was ill and unable to work for some specified period of time, and specifying restrictions for return to work and accommodation purposes when and as appropriate, would be good enough

for all purposes and nothing further, including any diagnoses or even a statement of the nature of the illness or injury would be required. But that is not the real world, or at least not the one I am familiar with. Medical health professionals are also human beings. The fact is that they are not always entirely objective. It is quite appropriate for medical health professionals to act as advocates for their patients in medical matters within their competence, but not when the advocacy extends beyond their medical expertise or matters of which they have direct knowledge, such as when they have little or no knowledge of the workplace or their patient's job or employment situation other than what their patient decides to tell them.

41. Having said that, this case concerns nurses employed in a hospital setting. As a group, physicians are uniquely situated to assess a nurse's ability to work in a hospital. A physician is likely to know more about the work that a nurse patient typically performs than he does about the work that other patients are engaged in. A physician is likely to know what sort of nurse his patient is and the nature of the work in the department she works in, and is therefore likely to be in good position to assess her ability to perform the work of her occupation.

42. Arbitrators who have concluded that particular collective agreements do not require medical diagnoses to be disclosed to the employer have observed that the employer can often guess the diagnosis from the restrictions or other accommodations that are suggested by a doctor. That is, a diagnosis can often be discerned even when it is not specifically stated. If so, one might well ask: so why not provide the diagnosis? And how can one reasonably object to providing information which will probably also disclose the diagnosis when that information is reasonably required for return to work or accommodation purposes? Is the situation different when an employee is seeking STD benefits? And if it is, and strict limits are imposed on the use of the information that must be disclosed in the first instance for those purposes, what is the likely result? Could limiting an employer's access to confidential medical information result in applications for sick leave benefits being rejected more often, perhaps requiring more frequent resort to the expensive and time-consuming grievance arbitration process? If so, how does it serve the employee seeking benefits, the privacy interests of that employee, the interests of the parties, or the health system?

43. First of all, the issue before me concerns the Hospital's entitlement (through its agent Cowan) to confidential medial information in the first instance. The fact that additional information may subsequently be required does not mean that the employer is entitled to it in the first instance.

44. Second, it is true that if the matter goes to arbitration, the employee will have to establish that she is (or was) entitled to the benefits. To establish this, it will generally not be good enough to present a doctor's certificate stating only that the employee was disabled and unable to work for a specific or indefinite period. The employer will be entitled to test the claim and the doctor's assertion by questioning the employee and requiring that the doctor to attend the hearing and give evidence, something that even the most cooperative doctors do not like to do. The employer will be entitled to examine the basis for the simple certificate, which will inevitably include what the doctor did or did to do, his/her knowledge of the patient and the workplace, and what conclusions, including the diagnosis, and the basis for the conclusions s/he arrived at. The employee's personal and medical history will be subject to much more detailed and intense scrutiny at such a hearing, and in a much more public forum, than is the case in the normal benefits application process. At the end of a lengthy, and for the employee an arduous and often nerve-wracking legal proceeding, the employee may well be awarded the benefits sought, which benefits may well have been approved many months before in the first instance if more information had been provided in the first place. That is, there is a danger that an employee will not receive benefits that she is entitled to in a timely way, when they are most needed.

45. But the real world also includes a society mandated legislated right to privacy, and the fact that narrow disclosure of medical information may have unfortunate or unintended consequences in an individual case, or that broad disclosure of medical information may be appropriate or required in preparation for or during a grievance arbitration (or other legal) proceeding does not alter the analysis. Either an employee has privacy rights or she does not. A right that cannot be exercised is no right at all. Although early broad disclosure might prove to have been useful in a particular case, this does not mean that such broad disclosure is necessary or appropriate in the first instance in every case as a matter of general policy. There are many business or other matters on both sides of the labour relations divide that are "confidential" outside of the grievance litigation

process which are no longer confidential for litigation purposes once the grievance arbitration process is invoked. That does not suggest that they should not remain confidential outside of the litigation process. Indeed, the legislative scheme treats litigation disclosure requirements or obligations as an exception to the general rule of voluntary consent restricted to the purpose disclosure of personal health information.

46. The appropriate requirements and concomitant limitations on the disclosure of confidential medical information is also something that the parties to a collective agreement can address themselves to in bargaining. In a particular case, the possible consequences of refusing to provide broader disclosure than is technically required in the first instance is something for the individual employee to weigh, hopefully in consultation with the Union, when she is considering her response to a request for confidential medical information. It is also one of the things that the parties and the employee(s) must consider when they contemplate engaging the grievance litigation process. But the real significance of the real world analysis is that it focuses on individual circumstances and further demonstrates that less disclosure of confidential information is required in the more general first instance inquiry than in an individual case in which questions arise.

IV. DECISION

47. Turning to the case at hand, I begin by looking at the legislation and collective agreement.

Legislation

48. The PHIPA is a comprehensive piece of health care privacy legislation. It recognizes the confidentiality of personal medical information and, among other things, establishes rules for the collection, use and disclosure of personal health information to protect the confidentiality and privacy of that information. Relevant excerpts from the PHIPA are set out in Appendix "D". Section 63(6) of the OHSA contains a medical information privacy provision which prevails over the PHIPA (see Appendix "E"). I have already noted that the parties to a collective agreement are bound by and cannot contract out of this legislation.

49. The legislation reflects the modern approach to the issue and emphasizes the individual employee right to keep confidential medical information private except where it is absolutely necessary to disclose it. The PHIPA makes it clear that the individual's freely given (i.e. uncoerced) express or implied informed consent regarding specific personal health information must be obtained before any such information can be collected used or disclosed (section 18) and that personal health information shall only be collected, used or disclosed to the extent reasonably necessary to serve the particular purpose (sections 30 and 37). The OHSA, which prevails over the PHIPA, specifies that no employer (or its agents) shall even seek access to a worker's health records except under authority of a court or tribunal of competent jurisdiction or as required by law without the worker's consent (section 63).

The Collective Agreement

50. The collective agreement between the parties in evidence is in two parts: the "Central Agreement", which as its label suggests is negotiated (or arbitrated) centrally between the "Participating Hospitals" as a group and the Union, and the "Local Agreement" negotiated directly between the Hospital and the Union. The Central portion of the collective agreement between the parties includes the following sick leave provisions:

> **ARTICLE 12 – SICK LEAVE AND LONG-TERM DISABILITY**
>
> (Articles 12.01 to 12.11 apply to full-time nurses only)
>
> 12.01 The Hospital will assume total responsibility for providing and funding a short-term sick leave plan at least equivalent to that described in the 1980 Hospitals of Ontario Disability Income Plan brochure.
>
> The Hospital will pay 75% of the billed premium towards coverage of eligible employees under the long-term disability portion of the Plan (HOODIP or an equivalent plan). The employee will pay the balance of the billed premium through payroll deduction. For the purpose of transfer to the short-term portion of the disability program, employees on the payroll as of the effective date of the transfer with three (3) months or more of service shall be deemed to have three (3) months of service. For the purpose of transfer to the long-term portion of the disability program, employees on the active payroll as of the effective date of the transfer with one (1) year or more of service shall be deemed to have one (1) year of service.
>
> ...

12.05 Any dispute which may arise concerning a nurse's entitlement to short-term or long-term benefits under HOODIP or an equivalent plan may be subject to grievance and arbitration under the provisions of this Agreement. The Union agrees that it will encourage a nurse to utilize the carrier's medical appeals process, if any, to resolve disputes.

...

12.11 A nurse who is absent from work as a result of an illness or injury sustained at work and who has been awaiting approval of a claim for Workers' Compensation for a period longer than one complete pay period may apply to the Hospital for payment equivalent to the lesser of the benefit the nurse would receive from Workers' Compensation if the nurse's claim was approved or the benefit to which the nurse would be entitled under the short-term sick portion of the disability income plan (HOODIP or equivalent plan). Payment will be provided only if the nurse provides evidence of disability satisfactory to the Hospital and a written undertaking satisfactory to the Hospital that any payments will be refunded to the Hospital following final determination of the claim by The Workplace Safety and Insurance Board. If the claim for Workers' Compensation is not approved, the monies paid as an advance will be applied towards the benefits to which the nurse would be entitled under the short-term portion of the disability income plan. Any payment under this provision will continue for a maximum of fifteen (15) weeks.

(Articles 12.12, 12.13 and 12.14 apply to both full-time and part-time nurses)

12.12 Nurses returning to work from an illness or injury compensable under Workers' Compensation will be assigned light work as necessary, if available.

...

12.14 If the Employer requires the employee to obtain a medical certificate, the employer shall pay the full cost of obtaining the certificate.

NOTE: This clause shall be interpreted in a manner consistent with the *Ontario Human Rights Code.*

(Emphasis added.)

The Local portion of the collective agreement contains the following management rights provision:

ARTICLE C - MANAGEMENT RIGHTS

C-1 Except as specifically abridged, delegated, granted or modified by this Agreement, all the rights, powers, and authority of management are retained by the management and remain exclusively and without limitation within the rights of management.

C-2 Without limiting the generality of the foregoing, management's rights include:

a) The light to maintain order, discipline and efficiency, and in connection therewith to make, alter and enforce from time to time, reasonable rules and regulations, policies and practices, to be observed by its' employees, and the right to discipline or dismiss employees for just

cause.

b) The direction of the working forces; the right to plan, direct and control the operation of the Hospital, the right to introduce new and improved methods, facilities and equipment, the right to determine: the amount of supervision necessary, combining or splitting up departments, work schedules, establishment of standards and quality of care, the determination of the extent to which the Hospital will be operated and the increase or decrease in employment.

c) The right to select, hire, discipline, dismiss, transfer, assign to shift, promote, demote, classify, lay-off, recall, suspend employees and select employees for positions not covered by this Agreement.

d) The sole and exclusive jurisdiction over all operations, buildings, machinery and equipment vested in the Hospital.

C-3 The exercise of any of these rights will not be inconsistent with the provision of this Agreement.

51. Notwithstanding Article 12.01, it is common ground that the 1980 Hospitals of Ontario Disability Income Plan ("HOODIP") applies to bargaining unit nurses hired before January 1, 2006 and that under the current collective agreement the 1992 HOODIP applies to bargaining unit nurses hired on or after January 1, 2006. There is no suggestion that the HOODIPs do not form part of the collective agreement between the parties. This being a forward-looking policy grievance, it is appropriate to consider the implications of both, notwithstanding that the grievances predate the actual introduction of the 1992 HOODIP.

52. The 1980 HOODIP provides (with emphasis added) that it:

> ... consists of two periods of benefits, the Sick Pay Benefit and the Long Term Disability Benefit. These cover the periods before and after the payment of disability benefits by the Unemployment Insurance Commission.
>
> For the purposes of the Sick Pay Benefit and the Long Term Disability Benefit, "total disability" and "totally disabled" mean, during the first 104 weeks you are absent from work, that you are unable to perform the regular duties pertaining to your occupation due to injury or illness and that you are not engaged in any gainful occupation. After 104 weeks, you must be prevented, by injury or illness, from engaging in any gainful occupation for which you are or may become fitted by training, education or experience.
>
> REINSTATEMENT OF BENEFIT

When you return from an absence and work full-time continuously for three weeks, your benefit period of 15 weeks is reinstated in full. If you are absent from work again due to total disability for the same or a related cause or before you have completed three weeks of full-time employment, the balance of your original sick pay benefit will apply. However, if your subsequent absence is due to a different illness unrelated to the initial one, the full 15-week benefit period will apply even if the absence due to the second illness occurs within three weeks following your return to work.

PROOF OF DISABILITY

Proof of your total disability satisfactory to your employer such as a doctor's certificate is required for absences of three days' duration or over, and is subject to a periodic review thereafter. However, such proof may be required at any time in order for you to qualify for benefits.

(Emphasis added.)

The 1992 HOODIP contains relevant provisions as follows:

Introduction

The Hospitals of Ontario Disability Income Plan ("HOODIP") is comprised of two parts: the short term disability plan (Part A) and the long term disability plan (Part B) ... the Sick Pay benefit (Part A), covering the first 15 weeks of Total Disability. The Sick Pay benefit is administered and paid by the Participating Employer...

Definitions

...

Actively working and Actively at Work mean the performance for a Participating Employer of the regular duties of the person's own occupation for one full working day or shift. This includes vacation days, personal days and/or holidays as well as occasional days used for educational purposes or union business, as granted by the Participating Employer. An Employee on extended leave, such as an approved leave of absence, is not considered to be Actively at Work.

...

Total Disability and Totally Disabled means the Member has a medically determinable physical or mental impairment due to injury or illness which prevents her from performing the regular duties of the occupation in which she participated immediately preceding the start of the disability.

...

Entitlement to Benefit

...

A Member is not considered Totally Disabled unless she is under the active, continuous and medically appropriate care of a Physician and is following the treatment prescribed by the Physician for that disability.

...

A Member is not considered Totally Disabled due to a psychological disorder unless she is under the active and continuous care of a Physician or other professional satisfactory to the Participating Employer and is following the treatment prescribed by the Physician or other professional for that disability.

...

Recurrence of Disability

Recurrence

If a member returns to work after receiving Sick Pay benefits under this Plan any subsequent period of Total Disability for the same or related cause will be considered as a continuation of the previous benefit period, unless the successive periods of Total Disability are separated by a period where the Member is Actively at Work for:

1. three regular work weeks for full-time employee; or

2. all of the scheduled working days within 21 calendar days for a part time employee,

in which case her benefit period of 15 regular work weeks will be reinstated in full.

...

(Emphasis added.)

53. The Union acknowledges that in the past individual employees have given the Hospital a broad consent and access to their confidential medical information, and that such broad access may be appropriate in a particular case. Indeed a review of the Attending Physician's Statements that were used by the Hospital's EHS Department pre-Cowan (see Appendix "AA") reveals that they too asked for a primary diagnosis, whether the employee had previously suffered form the same or a similar condition, any conditions or secondary diagnosis underlying the current illness, whether the employee had been hospitalized and when, whether the employee had undergone surgery as well as the date of the surgery and the name of the surgeon, whether a specialist was involved or had been consulted, and the treatment and dates that it had been provided. That is, there are many similarities between the intrusive questions in the EHS form, to which it appears the Union did not

object, and those that the Union complains about in the Cowan form. However, the consent that was required by EHS Attending Physician's Statements was much narrower than the disputed consent in the Cowan form. The consent in the Attending Physician's Statements was limited to the treating physician (as opposed to "any party involved in my treatment" in the Cowan form), and it restricted the information that could be passed through the "Chinese wall" between the Hospital and its EHS Department to a statement indicating whether the employee was unfit for work, fit to work with restrictions or fit for regular work, and the return to work date if known (as opposed to the far broader disclosure and use of information contemplated by the Cowan consent).

55. But none of that is really significant. The fact that the Union did not complain about an EHS form that required similar disclosure or that individual employees have given broad consent and access to their confidential medical records in the past, with or without the knowledge or participation of the Union is neither here nor there. The personal nature of confidential medical information is such that permission to access it may be revoked at any time, subject to the consequences of doing so. Except where the issue is one of interpretation of collective agreement provisions in that respect, the concepts of past practice or estoppel do not apply. That is, the fact that an individual employee or bargaining unit employees as a group have voluntarily permitted an employer broad access to confidential information in the past, or that their union has acquiesced to this, does not mean that either the employees or the Union must continue to do so.

56. There are significant relevant differences between the 1980 and 1992 HOODIPs. Under the 1980 HOODIP "total disability" for STD benefit purposes means an inability to perform "the regular duties pertaining to your occupation" because of illness or injury and requires proof "satisfactory to your employer such as a doctor's certificate". Under the 1992 HOODIP "total disability" for STD benefit purposes means "a medically determinable ... impairment" because of illness or injury that prevents the employee from performing "the regular duties of the occupation" when the disability began. In order to be entitled to the STD benefit, the employee must be "under the active, continuous and medically appropriate care" of an appropriate medical professional "and is following the treatment prescribed" for the disability.

57. For STD benefit purposes, "medically determinable" really means no more than "which has been determined by a medical professional" in order to eliminate any suggestion that an employee's subjective assessment or one by someone other than a medical professional might be sufficient. I am satisfied that the definition of "total disability" (and the concomitant "totally disabled") is the substantially same under both HOODIPs; namely, an employee's medically confirmed inability to perform the regular duties of her occupation due to illness or injury.

58. Under the 1980 HOODIP, all that is required to establish "total disability" for STD benefit purposes is proof "satisfactory to your employer such as a doctor's certificate". "Satisfactory to your employer" does not imply either a subjective test or broad employer discretion with respect to the proof that can be required. The test is one of objective reasonableness. Further, the phrase is modified by "such as a doctor's certificate", which must be interpreted in light of the significant privacy protections legislated for confidential personal medical information. Accordingly, this provides an example of what is deemed to be objectively reasonable proof for 1980 HOODIP STD purposes: namely, a doctor's certificate or the equivalent, which I am satisfied means a certificate from a medical health professional qualified to make the medical assessment attested to. That is, in the first instance under the 1980 HOODIP, the employer is not entitled to more than a certificate from a qualified medical health professional that states that s/he has assessed the employee as being incapable working at her occupation due to illness or injury for a specified period, the general nature of the illness or injury, that the employee is undergoing treatment (without specifying what it is), and the anticipated return to work date. The employer can only obtain additional confidential medical information if it has objectively reasonable grounds to doubt the accuracy, truth or adequacy of the certificate. There is nothing in the legislation or the collective agreement (which includes the 1980 HOODIP) which entitles the employer to a diagnosis or recital of symptoms, a medical history, the tests or other investigations performed, the treatment plan, or a prognosis other than the expected return to work date and identification of any accommodation requirements at that time.

59. There are significant differences between the 1980 and 1992 HOODIPs. The 1992 HOODIP requires proof that the employee seeking STD benefits has a medically determinable impairment (i.e. that a medical health professional has assessed the employee and concluded that

she is has an injury or illness which medically prevents her from performing the regular duties of her own occupation for a specified period) and that she is "under the active, continuous and medically appropriate care" of an appropriate medical professional "and is following the treatment prescribed" for the disability. Under the 1992 HOODIP for other than a psychological disorder the employee must be under the care of a physician, not any other kind of medical professional, which suggests that the proof of disability must come from a physician. In the case of a psychological disorder the employee must be under the "active and continuous care" of a physician or other professional satisfactory to the employer. That means that in the case of a psychological disorder the employer can choose the physician or other professional who the employee is assessed and cared for by for STD benefit purposes. The requirement in the 1992 HOODIP that the employee be under "medically appropriate care" and is following the treatment prescribed entitles the employer to proof from the physician or (in the case of a psychological disorder) other professional that the employee is under his/her active, continuous and medically appropriate care for the disability. This requires more than a mere attestation to that effect. After all would any physician or other professional attest that a patient was receiving anything other than medically appropriate care? Under the 1992 HOODIP the employer is entitled to make its own assessment of the medical appropriateness of the care.

60. Accordingly, in the first instance under the 1992 HOODIP the employer is entitled to a statement from a physician, or in the case of a psychological disorder from a physician or other professional satisfactory to the employer, that states that s/he has assessed the employee as being incapable of performing the regular duties of her occupation due to illness or injury for a specified period, the general nature of the illness or injury, that the employee is under his/her active and continuous care, a description of the treatment plan and an attestation that the employee is following the treatment prescribed, and the anticipated return to work date.

61. In the first instance under the 1992 HOODIP, the employer is still not entitled to a primary or secondary diagnosis or symptoms, or to particulars of the employee's medical history, or the tests or other investigations performed, or to a prognosis other than the expected return to work date and identification of any accommodation requirements at that time. The employer can only obtain confidential medical information in excess of the broader medical statement it is initially

entitled to under the 1992 HOODIP if it has an objectively reasonable basis for doubting the accuracy or truth of the information provided in the first instance.

62. The employer is entitled to more confidential personal medical information under the 1992 HOODIP than under the 1980 HOODIP but in the first instance in both cases the employer is not entitled to more than the medically appropriate attestation as aforesaid unless it has an objectively reasonable basis for doubting the accuracy or truth of the information provided. In the first instance an employer is not entitled to require an employee seeking STD benefits under either HOODIP to consent to the release of more medical information than it is entitled to.

Conclusion

63. I am satisfied that the Section B – Consent Information of the Cowan form overreaches. First, the consent should be limited to the treating physician (or other professional in the case of a psychological disorder under the 1992 HOODIP). If there is more than one medical or other professional involved a separate consent is required for each. Second, there is no *prima facie* basis for including any reference to an automobile insurer, which is likely to provide only second hand information if the employee's disability arose out of a motor vehicle accident with respect to which an insurance claim was made. There is no basis for including any reference to the WSIB which operates under a separate statutory insurance scheme for workplace injuries, and which provides its own disclosure (including forms to be completed by the accident employer and the treating medical professionals), adjudication and return to work process. Neither an employer nor any agent of the employer can purport to "adjudicate" a WSIB claim. If the WSIB process is engaged and Cowan's assistance is required that is a separate matter and is *prima facie* not part of the STD benefits claim process. Third, neither the Hospital nor Cowan can seek access to "all information and documents requested concerning [the employee's] medical condition relative to this claim for the purpose of facilitating the delivery of the best medical care and assessment of [the employee's] ability to work." It may not be the place of a medical health professional to assess an employee's entitlement to STD benefits under either HOODIP (but see my observation in paragraph 41, above, regarding the likelihood that physicians are likely to be more familiar with the duties and responsibilities of nurses in a hospital environment and able to assess their ability to perform the

same, than of other occupations), but how can it not be the place of the treating physician or other professional who actually examines and treats the employee/patient to assess the employee's ability to work and to determine and facilitate treatment? How can it be the place of someone who may be less qualified (and who may not even be a medical health professional) and who has never met the employee or been in the workplace to assess that employee's ability to work – particularly when they could only do so on the basis of the information provided by the very professional who the Hospital and Cowan assert cannot do so? Fourth, an undertaking to hold all medical information obtained confidential is appropriate, but the employee should not at the same time be required to consent to the disclosure of more information than the Hospital is entitled to. Disclosure should be limited to that expressly authorized by the employee or as required or permitted by law. Fifth, the employee should never be cut out of the communication loop. Direct contact between the employer (or its third party agent) and the employee's medical caregivers without the employee's knowledge or consent is prohibited. In order to give the employee an opportunity to object, the employee should be advised in advance of any such communication in any event. Sixth, the collective agreement clearly specifies (in Article 12.14 of the Central portion) that the employer shall pay the full cost of obtaining the certificate. It is wrong to imply that the employee may be responsible for any amount in excess of $35.00 (or any other amount). There should be no reference to the medical professional's fee, either maximum or otherwise in consent, or indeed anywhere in the Cowan form. Since it is the Hospital, either directly or through its agent Cowan, who is responsible for payment that matter is best dealt with as a separate matter directly between (in this case) Cowan and the medical health professional, perhaps in a separate or covering letter.

64. The Union's complaint about the form of letter (whish I observe refers to only the 1992 HOODIP – see paragraph 10, above) that is sent to employees along with the Cowan form may be an overreaction, but I appreciate the Union's concern when the letter is read together, as it must be, with what I have concluded is the overly broad consent in the Cowan form. I am satisfied that it is not improper coercion to inform an employee that they may be disqualified form receiving STD benefits if they fail to provide the <u>appropriate</u> medical or other information that the Hospital and Cowan are entitled to.

65. As for Section C – Medical Information, I suggest that separate forms are required for employees covered under the 1980 HOODIP and those covered under the 1992 HOODIP.

66. In the first instance under the 1980 HOODIP the Hospital and Cowan are only entitled to a certificate from a qualified medical health professional that states that s/he has assessed the employee (including the date(s) of the examination/assessment) as being incapable working at her occupation (which should be specified) due to illness or injury for a specified period, a statement of the general nature of the illness or injury, a statement that the employee is undergoing treatment (without disclosing the treatment or treatment plan), and the expected return to work date and any accommodation requirements likely to be required at that time.

67. In the first instance under the 1992 HOODIP the Hospital and Cowan are only entitled to a statement from a physician, or other professional in the case of a psychological disorder, that states that s/he has assessed the employee (including the date(s) of the examination/assessment) as being incapable of performing the regular duties of her occupation (which occupation should be specified) due to illness or injury for a specified period, a statement of the general nature of the illness or injury, that the employee is under his/her active, continuous and medically appropriate care for the disability, a description of the treatment supplied, the treatment plan and an attestation that the patient is following the treatment prescribed, and the expected return to work date and any accommodation requirements likely to be required at that time.

68. Under both the 1980 and the 1992 HOODIP the Hospital is also entitled to know when the illness began or the accident occurred and when the employee became unable to attend work, and the date of the first medical examination. It might also be useful for the Hospital to know whether the illness or injury is work-related so that the WSIB process can be engaged if appropriate. However, I am not sure that is necessary because I expect that nurses know enough about the WSIB process, with or without the assistance of the Union, to know when it is appropriate to engage it. The Hospital is not entitled to the other information sought on the Cowan Form "wish list". As the Hospital's agent Cowan is not entitled to diagnoses, symptoms, medical history, the specifics of medical investigation or current findings, treatment or prognosis other than as indicated above. This entire section will therefore have to be significantly revised in accordance

with this Award. In the first instance, the Hospital is not entitled to all of the information on the Cowan form "wish list".

69. The Hospital or its agent Cowan can ask an employee to volunteer additional confidential information, but in the first instance that should be done on a separate form or at least a separate page that makes it clear that the employee is not obliged to make the disclosure and which requires a separate consent for each parcel of confidential personal medical information. (The information requested should not be as a single package because an employee may be willing to disclose some but not other voluntary information.) If the Hospital or Cowan has reasonable cause to doubt the accuracy or *bona fides* of the information provided in the first instance, or if that information is objectively insufficient for STD benefits purposes in the circumstances of a particular case, they can seek specific broader disclosure. Doing so will engage an individualized process.

70. In the result, this part of the grievances must be allowed. Accordingly,

(a) **I DECLARE THAT** the Cowan form is improper because it requires employees to consent to a release of private personal medical information in excess of what the Hospital or its third party agent Cowan is entitled to in the first instance for either STD benefits or return to work purposes under either the collective agreement or otherwise.

(b) **I ORDER THAT** use of the current Cowan form cease forthwith.

(c) **I ORDER THAT** a new form or forms may be constructed for STD benefits purposes, which form(s) must comply with this Award.

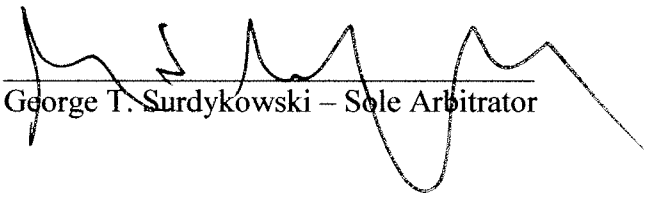
(d) **I ORDER THAT** the Hospital to ensure that its third party agent Cowan complies with this Award.

(e) **I WILL REMAIN SEIZED** for the purposes of rectification, and to deal with any issues arising out of the implementation of this Award. In order to relieve the parties of the time and expense of litigating the propriety of any new Cowan or other form that is constructed

for use in administering the STD benefits under either the 1980 or the 1992 HOODIPs anew or before another arbitrator, I will remain seized to deal with any issues in that respect as well.

71. I recognize that this Award may result in a somewhat cumbersome process, but rights are rights and employees who seek STD benefits are just as entitled to stand on their legislated or collective agreement privacy rights as anyone else.

DATED AT TORONTO THIS 5TH DAY OF OCTOBER 2007.



George T. Surdykowski – Sole Arbitrator

Appendix "A"

Cowan
Cowan Wright Beauchamp

MEDICAL CERTIFICATE OF DISABILITY

Send completed form marked "confidential" to: Health and Disability Management Programs
Cowan Wright Beauchamp
100 Regina, St. S., Suite 270, Box 96 Waterloo, Ontario, N2J 3Z6
or fax at: (519) 886-2163

Section A– General Information (To be completed by employer)

Employee Name: _____ Job title: _____

Address: _____
City Province Postal Code

Date of Birth: ___/___/___ (DD MM YY) Date of employment: ___/___/___ (DD MM YY) Last Day Worked: ___/___/___ (DD MM YY)

Employee's Home Phone #: ( ) _____ Work Phone #: ( ) _____

Section B – Consent Information (To be completed by employee)

I authorize any party involved in my treatment including any health care professional, the WSIB or the Automobile insurer to provide our Medical Service Provider, Cowan Wright Beauchamp (CWB), all information and documents requested concerning my medical condition relative to this claim for the purpose of facilitating the delivery of the best medical care and the assessment of my ability to work. All information will be treated in a highly confidential manner, however, information regarding restrictions or limitations affecting my ability to Return to Work could be shared in a report to Supervisors and when applicable, WSIB, the Automobile insurer and the Long Term Disability Insurer. A photocopy or other reproduction of this authorization is as valid as the original. **The employer will reimburse up to a maximum of $35.00 for appropriate completion of this form upon presentation of an original receipt. Receipts may be mailed to: Hamilton Health Sciences Corporation, Health, Safety & Wellness, 1200 Main St., W., Ewart Building-206, Chedoke Site Hamilton, Ontario L8N 3Z5**

Employee's Signature: _____ Date: ___/___/___ (DD MM YY)

Section C – Medical Information (To be completed by Employee's Physician)

In order to support the medical absence of this employee and to facilitate his-her return to work we require specific information. The Hamilton Health Sciences is committed to providing a transitional-modified work program for its personnel and requires your guidance to ensure a timely and safe return to work. Cowan Wright Beauchamp has been mandated to review all medical absences of five (5) shifts or greater, to determine if the employee is able to return to work and co-ordinate the employee's recovery and return to work. **This certificate will be deemed incomplete unless all sections are completed satisfactorily.**

1. Diagnosis:

Primary: _____ Symptoms: _____

Secondary: _____ Symptoms: _____

Other contributing factors-complications: _____

2. History:

Symptoms began or accident happened on: ___/___/___ (DD MM YY) First visit: ___/___/___ (DD MM YY)

Illness or injury forced cessation of work on: ___/___/___ (DD MM YY) Is this a work-related illness-injury? ____Yes ____No

Has your patient ever had the same or a similar condition? ____Yes ____No ____Unknown

If yes, state when and describe the condition: _____

_____

Has your patient been hospitalized: ____Yes ____No If yes, please indicate dates: ___/___/___ (DD MM YY) to ___/___/___ (DD MM YY)

3. Current findings:

When did you most recently examine your patient? ___/___/___ (DD MM YY)

What were your findings on this examination date? _____

_____

What functional limitations affect your patient's ability to perform his/her normal activities, including work?

_____

_____

_____

_____

What investigations have been done? Please list specific tests below:

Tests done (e.g. EKG's, x-rays, lab tests)	Summary of results

4. Treatment

Date of last visit: ___/___/___ (DD MM YY) Date of next visit: ___/___/___ (DD MM YY)

Identify the current medications and dosages prescribed as well as the response to these medications: _____

_____

_____

Therapy? ____Yes ____No If "Yes", indicate type and frequency (e.g. physiotherapy, psychotherapy)_____

_____

Surgery? ____Yes ____No If "Yes" type of surgery: _____

Date: ___performed ___planned ___/___/___ (DD MM YY)

Any other treatment or future plans for treatment? _____

_____

Summarize patient's response to treatment: _____

_____

Has your patient been referred to any other physician(s) -- specialist(s)? _____Yes ____No

If "Yes" Physician's name and specialty	Date of examination Day Month Year	Findings

5. Prognosis

Please provide details about the return to work plan, including approximate time frames (full time work or modified work / schedule).

_____

_____

Notice to physician: Any information provided by you to the Medical Service Provider may be disclosed to the patient and/or those authorized by him/her to receive such disclosure.

Physician's signature: _____ Date ___/___/___ (DD MM YY)

Print name: _____ Phone number ( ) _____

Health and Wellness

ATTENDING PHYSICIAN'S STATEMENT

Please complete this form and return it to your patient.

Patient's Name: _____
Date of Birth: _____ / _____ / _____ *(yy/mm/dd)*
Primary Diagnosis: _____
Is this a Worker's Compensation Board case? *Yes* _____ *No* _____
When did patient first consult you for this condition? ____ / ____ / ____ *(yy/mm/dd)*

To the best of your knowledge:
a) When did symptoms first appear or accident happen? ____ / ____ / ____
b) Has the patient ever had the same or similar condition? *Yes* _____ *No* _____
If yes, state when and describe:

_____
_____
_____

Identify any underlying conditions or secondary diagnosis affecting the present illness:

_____
_____
_____
_____

Has the patient been hospitalized with the primary conditiion? *Yes* _____ *No* _____
If yes, state where? _____
Dates: _____

If surgery has been performed for this condition, please state:
What procedure: _____
Dates: _____
Surgeon: Dr. _____

Identify any specialists involved in care/consultation for this condition?
Dr. (s): _____

Please outline the treatment provided for this condition:

_____
_____
_____
_____
_____

Please identify dates of your treatments of the patient for this condition within the past month:

To the best of your knowledge, indicate the dates that your patient has been totally disabled (unable to work in any capacity):
From: ____ / ____ / ____ (*yy/mm/dd*)
To: ____ / ____ / ____ (*yy/mm/dd*)

Can the patient return to usual work now? *Yes* _____ *No* _____
If no, can he/she return to modified work now? *Yes* _____ *No* _____

a) If yes, what specific restrictions (eg. Hours, postures, lifting)?

---

b) If no, your best estimate of date able to return?

When do you plan to see your patient next for this condition?

Other comments

Your name: Dr. _____
Practice Address: _____
_____
Telephone #: _____
Signature: _____
Date: ____ / ____ / ____ (*yy/mm/dd*)

Authorization for Release of Information

I hereby authorize my treating Physician to complete this form and for this information to be released to my confidential medical file in Employee Health Services, Hamilton Health Sciences.

I consent for Employee Health Services to release only the following limited information to Hamilton Health Sciences, based on my Doctor's report.

a) Fitness for work. A statement indicating whether I am unfit for work, fit to work with certain restrictions or fit for regular work.
b) Date of expected return to work if it is known. Hamilton Health Sciences may be notified if no return to work date has been determined.

Date: _____

Patient's Signature: _____

APPENDIX "B"

HAMILTON HEALTH SCIENCES CORPORATION

Functional Abilities Form

☐ Initial Form ☐ Follow-up

Workers Name _____ Address _____

City/Postal Code _____ Telephone # _____

Non-Occupational Injury/Illness Information:

The following information should be completed by the Health Professional:

Date of Examination on which the report is based	Area of Injury
Rehabilitation/Treatment Required? **On site Physiotherapy and Occupational Therapy services are available.** ☐ Yes ☐ No	Is the worker capable of returning to work immediately without restrictions? ☐ Yes ☐ No If no, please complete the next section.

Please complete where capabilites are known or limitations recommended. Note: 'as tolerated' implies that restrictions are recommended but must be quantified in the workplace.

Capabilities

Walking: short distance only ☐ as tolerated ☐ other (eg. uneven ground) ☐ _____
Standing: less than 15 min. ☐ less than 30 min ☐ as tolerated ☐ other ☐ _____
Sitting: less than 30 min. ☐ less than 1 hour ☐ as tolerated ☐ other ☐ _____
Lifting floor to waist: less than 10kg ☐ less than 25kg ☐ as tolerated ☐ other ☐ _____
Lifting waist to shoulder: less than 10kg ☐ less than 25 kg ☐ as tolerated ☐ other ☐ _____
Stair climbing: none ☐ 2-3 steps only ☐ short flight ☐ own pace ☐ as tolerated ☐
Ladder climbing: none ☐ 2-3 steps only ☐ 4-6 steps only ☐ own pace ☐ as tolerated ☐
Limited ability to use hand to: hold objects ☐ grip ☐ type ☐ write ☐

Limitations

☐ Bending or twisting of _____
☐ Repetitive movement of _____
☐ Chemical exposure to _____
☐ Environmental exposure to _____
☐ Operating motorized equipment _____
☐ Restrictions related to medications: (specify) _____
☐ Above-shoulder activity _____
☐ Below-shoulder activity _____

Exposure to vibration: high frequency ☐; low frequency ☐

Limited physical exertion to: mild ☐ ; moderate ☐; as tolerated ☐

General Comments/Specific Limitations

Recommendation for Work hours ☐Full-time hours ☐ Modified hours ☐ Graduated hours	Complete Recovery Expected? ☐ No ☐ Yes	Estimated Duration of Limitations
Health Professional's Name (Please Print)	Health Profession	Date of Next appointment for review of capabilities (dd/mm/yy)
Full Address	City/Town Province	Postal Code
Date	Area Code ( ) Telephone	Signature

The following should be filled in by the Worker:

By signing below, I am authorizing any health professional, now treating me, for an injury or disease to provide me, my employer and HHSC Insurance Carrier with information about my functional abilities for a timely Return to Work.

Employee Signature: _____ Date: _____

APPENDIX "C"

Health and Disability Management
Consulting Services

Service Agreement
between

Cowan Wright Beauchamp Limited

641 Montreal Road
Ottawa, ON K1K OT4

100 Regina Street South
Suite 270, Box 96
Waterloo, ON N2J 3Z6

and

Hamilton Health Sciences Corporation
Sanatorium Road
Hamilton, ON
L9G 3N5

Whereas Hamilton Health Sciences Corporation (HHS) administers and pays full income protection during illness absences ("sick leave") to its eligible employees.

And whereas HHS has requested that Cowan Wright Beauchamp Limited (CWB) provide professional sick leave assessment and other analytical services to HHS;

Effective January 10th, 2005, CWB is appointed by HHS to act as HHS's Health and Disability Management and third-party administrator to provide:

- Sick Leave Adjudication and Medical Case Management for all sick or injured employees of HHS during the Sick Leave and Employment Insurance (where applicable) period of absence.

Sick Leave Adjudication and Medical Case Management

HHS retains CWB to adjudicate sick leave claims received by them and to provide Medical Case Management. This service will include validating whether the employee's absence is due to a defined medical restriction, the review of factors relevant to the disability and the regular issuance of Case Management Reports. It may also include confidential and privileged communication with healthcare professionals involved and assistance and orientation of the employee with required healthcare services.

CWB's health professionals will provide recommendations concerning the eligibility for sick leave payment according to their respective code of ethics and standards of

practice (The College of Physicians and Surgeons of Ontario for CWB Medical Director, The Ontario College of Nurses for CWB Occupational Health Nurses and/or any other professional accreditation). The final decision regarding payment of sick leave benefits is ultimately HHS's responsibility.

HHS is responsible for providing the pertinent information to CWB in order to determine participant eligibility in accordance with the employer's policies and practices for sick leave benefits. CWB will rely upon the information provided by the employer concerning participant eligibility for its adjudication. HHS will communicate in a timely fashion all the necessary information related to the absence of an employee which may result from a medical condition. CWB will provide standard forms to HHS to facilitate the collection of the necessary information from both the employee and HHS.

CWB will provide professional sick leave adjudication and medical case management services to attend to the needs of employees who are away from work for five (5) or more consecutive shifts as a result of a non-occupational disability.

CWB' Sick Leave Adjudication and Medical Case Management Service includes:

- Decisions regarding the eligibility to sick leave benefit payments;
- Communication to HHS of any issues relevant to the disability that may hinder recovery;
- Communication with the employee as required during the Early Intervention program;
- Communication with healthcare professionals involved, if required, including payment of any related fees;
- Assistance and orientation of the employee to any required healthcare services;
- Monitoring and communication of case progress to all stakeholders;
- Early coordination of rehabilitation initiatives to facilitate a timely return to work;
- Communication of potential return to work parameters to the employer;
- Organization of independent assessments that may be necessary to facilitate recovery;
- Issuance of Case Management reports to the employer as needed and monthly summary reports;
- Upon our recommendation, it is HHS' responsibility to initiate the LTD claim applications. CWB will transmit, to the insurer, copies of documents relevant to the LTD claim, prepared by medical professionals, without prejudicial assessments.

Fees and Payment Terms

From January 10th, 2005 until February 28th, 2005 the Sick Leave Adjudication and Medical Case Management component will be provided on a fee-for-service basis based on CWB's hourly rates. During this period our services will include continued case management for the current groups and implementation assistance.

Starting March 1st, 2005, the above services will be provided on a monthly retainer of

_____. Fee for services will be reconciled monthly. Fees exceeding the retainer will be reconciled and billed the month following the reconciliation report. Where the retainer exceeds the fees owing, such surplus will remain in the account to be ultimately reconciled the following months. During the first 12 months of service the minimum fee paid to CWB will not be less than ____.

HHS and CWB agree to a Disability Management – Quality Service Standards model that will enhance the results of the program and provide a measurable benefit to HHS. The document will provide the basis of performance management. (See attached document and Scorecard) **[not provided]**.

CWB hourly rates (excluding GST) are:

- _____
- _____
- _____
- _____

(Above fees apply for 24 months. CWB reserves the right, with HHS approval, to increase fees for services beyond 24 months to a minimum of CPI.)

On-site communication including program launch, information sessions and any additional requests for attendance during the program period, including meetings with Managers and employees will be provided at a fix rate of ____ + GST.

HHS and CWB shall identify funds that may be required to reimburse referrals or consultations obtained through the Medical Case Management preferred healthcare provider network (Independent Medical Examinations, Functional Capacities Evaluations or facilitating diagnostic tests such as MRI). HHS will incur costs for these services. Prior to incurring these expenses, CWB will seek pre-authorization from HHS and any resulting payment or reimbursement will be determined.

Termination of Contract

Either party may terminate this agreement at any time by providing 60 days written notice.

Confidentiality

Information referred to in the Agreement, and any other confidential personal or medical information disclosed:

(i) by HHS or,

(ii) by or on behalf of employees of HHS,

to CWB for purposes of enabling CWB to provide the services under this Agreement, is referred to, collectively, as the "submitted information".

The submitted information by HHS to CWB shall only be used to provide the services

mentioned above. CWB will fully maintain, respect and protect the confidentiality of the medical and personal information received under this agreement and will not release it to any other party, unless such release is authorized *by* the employee and complies with all privacy law requirements. CWB may utilize such information for the preparation of Independent Medical Examinations or Functional Capacities Evaluations. CWB's healthcare professionals are operating under the confidentiality guidelines of their respective professional colleges. CWB will ensure safekeeping of all HHS employees' Medical Records incurred for the purpose of the above mentioned services for a period of 10 years, after which the files will be destroyed.

General

This Agreement is a contract made under and will be governed by and construed in accordance with the laws of the Province of Ontario and the federal laws of Canada applicable in the Province of Ontario.

This Agreement may be amended upon written consent of both parties.

APPENDIX "D"

EXCERPTS FROM THE *PERSONAL HEALTH INFORMATION PROTECTION ACT, 2004*

PART III
CONSENT CONCERNING PERSONAL HEALTH INFORMATION

GENERAL

Elements of consent

18. (1) If this Act or any other Act requires the consent of an individual for the collection, use or disclosure of personal health information by a health information custodian, the consent,

(a) must be a consent of the individual;

(b) must be knowledgeable;

(c) must relate to the information; and

(d) must not be obtained through deception or coercion.

Implied consent

(2) Subject to subsection (3), a consent to the collection, use or disclosure of personal health information about an individual may be express or implied.

Exception

(3) A consent to the disclosure of personal health information about an individual must be express, and not implied, if,

(a) a health information custodian makes the disclosure to a person that is not a health information custodian; or

(b) a health information custodian makes the disclosure to another health information custodian and the disclosure is not for the purposes of providing health care or assisting in providing health care.

Same

(4) Subsection (3) does not apply to,

(a) a disclosure pursuant to an implied consent described in subsection 20 (4);

(b) a disclosure pursuant to clause 32 (1) (b); or

(c) a prescribed type of disclosure that does not include information about an individual's state of health.

Knowledgeable consent

(5) A consent to the collection, use or disclosure of personal health information about an individual is knowledgeable if it is reasonable in the circumstances to believe that the individual knows,

(a) the purposes of the collection, use or disclosure, as the case may be; and

(b) that the individual may give or withhold consent.

Notice of purposes

(6) Unless it is not reasonable in the circumstances, it is reasonable to believe that an individual knows the purposes of the collection, use or disclosure of personal health information about the individual by a health information custodian if the custodian posts or makes readily available a notice describing the purposes where it is likely to come to the individual's attention or provides the individual with such a notice.

Transition

(7) A consent that an individual gives, before the day that subsection (1) comes into force, to a collection, use or disclosure of information that is personal health information is a valid consent if it meets the requirements of this Act for consent.

...

PART IV
COLLECTION, USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

GENERAL LIMITATIONS AND REQUIREMENTS

Requirement for consent

29. A health information custodian shall not collect, use or disclose personal health information about an individual unless,

(a) it has the individual's consent under this Act and the collection, use or disclosure, as the case may be, to the best of the custodian's knowledge, is necessary for a lawful purpose; or

(b) the collection, use or disclosure, as the case may be, is permitted or required by this Act.

Other information

30. (1) A health information custodian shall not collect, use or disclose personal health information if other information will serve the purpose of the collection, use or disclosure.

Extent of information

(2) A health information custodian shall not collect, use or disclose more personal health information than is reasonably necessary to meet the purpose of the collection, use or disclosure, as the case may be.

Exception

(3) This section does not apply to personal health information that a health information custodian is required by law to collect, use or disclose.

Use and disclosure of personal health information

31. (1) A health information custodian that collects personal health information in contravention of this Act shall not use it or disclose it unless required by law to do so.

(2) REPEALED: 2004, c. 3, Sched. A, s. 31 (4).

(3) REPEALED: 2004, c. 3, Sched. A, s. 31 (4).

(4) SPENT: 2004, c. 3, Sched. A, s. 31 (4).

...

USE

Permitted use

37. (1) A health information custodian may use personal health information about an individual,

(a) for the purpose for which the information was collected or created and for all the functions reasonably necessary for carrying out that purpose, but not if the information was collected with the consent of the individual or under clause 36 (1) (b) and the individual expressly instructs otherwise;

(b) for a purpose for which this Act, another Act or an Act of Canada permits or requires a person to disclose it to the custodian;

(c) for planning or delivering programs or services that the custodian provides or that the custodian funds in whole or in part, allocating resources to any of them, evaluating or monitoring any of them or detecting, monitoring or preventing fraud or any unauthorized receipt of services or benefits related to any of them;

(d) for the purpose of risk management, error management or for the purpose of activities to improve or maintain the quality of care or to improve or maintain the quality of any related programs or services of the custodian;

(e) for educating agents to provide health care;

(f) in a manner consistent with Part II, for the purpose of disposing of the information or modifying the information in order to conceal the identity of the individual;

(g) for the purpose of seeking the individual's consent, or the consent of the individual's substitute decision-maker, when the personal health information used by the custodian for this purpose is limited to the name and contact information of the individual and the name and contact information of the substitute decision-maker, where applicable;

(h) for the purpose of a proceeding or contemplated proceeding in which the custodian or the agent or former agent of the custodian is, or is expected to be, a party or witness, if the information relates to or is a matter in issue in the proceeding or contemplated proceeding;

(i) for the purpose of obtaining payment or processing, monitoring, verifying or reimbursing claims for payment for the provision of health care or related goods and services;

(j) for research conducted by the custodian, subject to subsection (3), unless another clause of this subsection applies; or

(k) subject to the requirements and restrictions, if any, that are prescribed, if permitted or required by law or by a treaty, agreement or arrangement made under an Act or an Act of Canada.

Agents

(2) If subsection (1) authorizes a health information custodian to use personal health information for a purpose, the custodian may provide the information to an agent of the custodian who may use it for that purpose on behalf of the custodian.

...

DISCLOSURE

...

Disclosures for proceedings

41. (1) A health information custodian may disclose personal health information about an individual,

(a) subject to the requirements and restrictions, if any, that are prescribed, for the purpose of a proceeding or contemplated proceeding in which the custodian or the agent or former agent of the custodian is, or is expected to be, a party or witness, if the information relates to or is a matter in issue in the proceeding or contemplated proceeding;

(b) to a proposed litigation guardian or legal representative of the individual for the purpose of having the person appointed as such;

(c) to a litigation guardian or legal representative who is authorized under the Rules of Civil Procedure, or by a court order, to commence, defend or continue a proceeding on behalf of the individual or to represent the individual in a proceeding; or

(d) for the purpose of complying with,

(i) a summons, order or similar requirement issued in a proceeding by a person having jurisdiction to compel the production of information, or

(ii) a procedural rule that relates to the production of information in a proceeding.

Disclosure by agent or former agent

(2) An agent or former agent who receives personal health information under subsection (1) or under subsection 37 (2) for purposes of a proceeding or contemplated proceeding may disclose the information to the agent's or former agent's professional advisor for the purpose of providing advice or representation to the agent or former agent, if the advisor is under a professional duty of confidentiality.

...

(Emphasis added.)

APPENDIX "E"

Section 63 of the Occupational Health and Safety Act

PART VIII
ENFORCEMENT

...

Information confidential

63. (1) Except for the purposes of this Act and the regulations or as required by law,

...

(f) no person shall disclose any information obtained in any medical examination, test or x-ray of a worker made or taken under this Act except in a form calculated to prevent the information from being identified with a particular person or case.

Employer access to health records
(2) No employer shall seek to gain access, except by an order of the court or other tribunal or in order to comply with another statute, to a health record concerning a worker without the worker's written consent.

...

Power of Director to disclose
(4) A Director may communicate or allow to be communicated or disclosed information, material, statements or the result of a test acquired, furnished, obtained, made or received under this Act or the regulations.

Medical emergencies
(5) Subsection (1) does not apply so as to prevent any person from providing any information in the possession of the person, including confidential business information, in a medical emergency for the purpose of diagnosis or treatment.

Conflict
(6) This section prevails despite anything to the contrary in the *Personal Health Information Protection Act, 2004.*

(Emphasis added.)