



**Presentation to:**

**Breaking Down the Barriers Conference Series:  
Patient Confidentiality and Return to Work**

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**Confidentiality as a Barrier to  
Accommodating Persons with Disabilities**

**By Lisa M. Doupe, M.D., D.I.H., D.O.H.S.**

I am very pleased to be here today because New Brunswick has been a leader in advancing work and health issues. Your own Dr. Margison has played a leading role as has Dr. Dana Hanson, the past President of the Canadian Medical Association, and Dr. Don Morgan, former Chair of the CMA Council on Health Care and Promotion. They have all played a key role in moving forward the issues relating to work and health. It was that committee that issued the Canadian Medical Association policy on the physician's role in work and health. New Brunswick's Andy Scott headed the Federal Task Force on Disability Issues. He also served as Vice-Chair of the Human Rights and Status of Persons with Disabilities Committee. Randy Dickinson, a leader in supporting people with disabilities, is Executive Director of the New Brunswick Premier's Council on the Status of Disabled Persons, and a former Executive Director of the Premier's Council on Health Strategy. New Brunswick is surely a leader in supporting people with disabilities.

Today, I will talk about the following issues and how each presents or helps to remove barriers to persons with disabilities. I want to raise the issue of what workplaces need in order to return people to work. And I want to discuss the need to de-link patient functional information from other types of medical information.

1. The Need for Attention to Work and Health
2. Evolution of the Round Table Project on Return to Function/Return to Work in Ontario
3. New Information – New Tools
  - Disability Prevention
  - Accommodation

- Potential Tools
  - International Classification of Functioning
  - Work Disability Diagnosis Interview
4. Medical Information – the Ethical Framework

We may find that new information and new tools will provide the solutions to current barriers to return to function and return to work. In the meantime, there is a lot of work to be done.

## 1. The Need for Attention to Work and Health

Human Resources Development Canada (HRDC) estimates that 3.6 million Canadians - one in eight people - have a disability. Persons with disabilities (PWDs) are our families and friends. And the numbers of PWDs will soon skyrocket due to the age demographic.

The cost of disability is high. According to Health Canada's Economic Burden of Illness, in 1998 (the latest year for which figures are available) the burden of illness was an estimated \$159.4 billion. That's up from \$97.2 billion in 1986. While the figures do not isolate "disability" *per se*, they are helpful in identifying the cost categories and general costs.

Statistics Canada reports that the average number of workdays lost per employee due to illness or disability (per year) is 7.0 in 2001, up from 6.2 in 1997. Productivity cost just in those terms is immense.

For the individual, delays compound the disability. If someone is off work for six months, the chance of getting back to work is 50%. If they are off for more than one year, the chance is 25% and if longer than two years, the chance is almost zero. When I have a patient in front of me who has not gotten back to work because the service provider sectors have not been able to create a system that appropriately supports them, that situation gives me and should give us all, the reason to work on resolving the barriers that face ill and disabled persons.

The Canadian demographic indicates that we will soon have the largest group of citizens over age 55 that we have ever had in our history. We are told that the numbers in the workforce are going to decline, so all workers, not only the older workers, but those who are injured and ill, will be needed more than ever before in our history. If the issues around return to work and the disabled have only concerned you professionally so far, they are almost certainly going to impact you, your organization and society in general in the near future, because skill shortages will impact service delivery and the economy across Canada.

Thus we must find ways to integrate the disabled into the work force appropriately. We must consider not only the job attached disabled, but also those who are not job attached.

Try to imagine if you had a complex injury or illness and could not work. Try to list all the support systems you would need. Are all the supports available when you need them or would you even know where to access the information you require? My experience in my clinical practice tells me the answer would be no.

Let me start at the beginning of how I became involved in this issue.

The Ontario Medical Association Policy on Timely Return to Work Programs and the Role of the Primary Care Physician was developed in response to the employers, unions, insurers, and physicians' comments that noted the confusion within the system.

The traditional role of medicine has been to diagnose and treat patients. The new policy introduced changes, which require the physician to facilitate and support the patient to return to function/return to work, and to cooperate with preventive approaches.

### **OMA TIMELY RETURN TO WORK MODEL OF DISABILITY MANAGEMENT**

The OMA recommends that the new program should include the following understandings:

1. When the patient is off work due to sickness or injury, he/she would bring an employer's proposed return to work program to his/her physician.
2. Physician provides objective reports on impairment, medical restrictions, and other supporting advice to the employee.
3. Employer offers the employee a plan for returning to suitable work in a timely fashion.
4. Employee and management have a primary responsibility to initiate a timely return to work that incorporates input from the physician.
5. Management control of "sick leave" abuse is through work place "culture" and timely return to work programs, not medical certification.

The Canadian Medical Association policy took the process a step further: The policy accomplished the following:

- It signaled the medical community's openness to work with other stakeholders towards common goals in return to work. 150 groups were part of the consultation during the development.

- It **redefined** the role of all physicians from that of diagnosis and treatment to include facilitating patients to return to function and return to work.
- It identified that what was needed in communications was a discussion about function and not medical information.
- It uncoupled medical treatment from return to function/return to work.
- It introduced non-pharmacological treatments such as personal protective equipment.

However, for physicians to support patients to function in daily life and particularly in the work force, the system must be designed (or now, redesigned) *along with all the other system players*. The challenge then is for all stakeholders in the system to then move with this policy and think how we can **educate** each of the stakeholder groups so that they understand their role in the system.

After the CMA policy was issued, Human Resources Development Canada (HRDC) asked what was needed next. It was apparent that the stakeholders who then were working in isolation needed to come together. This recognized need led to the formation of the Round Table Project.

## **2. Evolution of the Round Table Project in Ontario**

### **Round Table I**

At the first meeting of the Round Table Project in 1998, 26 representatives (22 organizations) of eight stakeholder sectors attended. Stakeholders identified development of a vision, common language and a service delivery model as priorities. Stakeholders decided there was value in continuing to meet and they welcomed the lead of Human Resources Development Canada in facilitating the process. They were looking for concrete opportunities to work together. As part of the process, stakeholder policies related to return to function/return to work were collected and analyzed. Not surprisingly, the lack of congruency among the policies became clear immediately.

### **Round Table II**

During the second Round Table Project meeting in 1999, representatives from 23 organizations representing 11 stakeholder sectors showed they could work together to develop a vision and priorities. The vision they adopted is the following:

*“To improve the systems that help people with illness, injury or disability from any cause, develop and secure their social, personal*

*and economic self-sufficiency, and to help stakeholders in the field identify and overcome barriers together.”*

### **Round Table III**

The Round Table in its third phase identified six themes:

1. Emergence of a **systems approach** to solving community problems,
2. **Alignment of visions and values** that are inclusive of all Canadians,
3. **Paradigm shift** from disability and mortality to ability and life,
4. **Redefinition of the role of medicine in RTF/RTW** by the medical community to include work,
5. **Emergence of evidence-based models** in RTF/RTW, and
6. Growing evidence that **people’s health drives economic productivity**.

I will be going into the third theme in greater detail.

Many studies have shown that the diagnosis or x-ray results do not predict level of functioning, presence of disease, or symptoms, nor are they a predictor of return to work, or likelihood of social reintegration.

In Ontario, the Workplace Safety and Insurance Board (WSIB) has de-linked medical diagnosis and treatment from functional abilities. Let me turn to the challenge of this conference, which is removing barriers, and the difficulties raised by medical confidentiality. With the introduction of new privacy legislation, the legal framework will have to define whether functional information is treated the same as medical information.

### **Legislation and Definition of Confidential Medical Information**

One must be aware that existing provincial legislation may include or exclude certain information as confidential medical information. For example, about 15 years ago, one of the guidelines developed to help occupational health physicians in Ontario by the Ontario Medical Association Section on Occupational and Environmental Medicine stated that occupational physicians should communicate with employers regarding the patients’ capabilities and restrictions in order to help patients to return back to work. However, when Bill 15, An Act to Amend the Workers’ Compensation and the Occupational Health and Safety Act, was promulgated when the New Democratic Party was in power, that bill stated that work restriction and work capacity information should be treated as confidential medical information. Physicians then had to ensure that worker consent was obtained before they undertook communications with employers. This meant that in the case of a worker who went off work and who had not completely recovered to do his/her original job and did not consent to the release of work capacity information, the employer would not be able to look for or offer a modified or more appropriate job for the worker.

## **Workers' Compensation Legislation in Ontario with Emphasis on Early Return to Work**

On November 26, 1996, the Progressive Conservative government tabled legislation that substantially overhauled Ontario's workers' compensation system. The bill, the *Workers' Compensation Reform Act*, repealed the entire *Workers' Compensation Act* and replaced it with a new statute called the *Workplace Safety and Insurance Act, 1996*. The Workers' Compensation Board (WCB) and the Workers' Compensation Appeals Tribunal were renamed the Workplace Safety and Insurance Board and the Workplace Safety and Insurance Appeals Tribunal respectively.

A key objective in the government's strategy was to retire the system's unfunded liability of \$10.7 billion by the year 2014, while at the same time reducing premiums paid by employers.

As part of the effort to get injured workers back to work, the new Act contains provisions concerning health care and health reports. When applying for benefits, an injured worker is now required to consent to the disclosure to the employer of records concerning the worker's functional abilities. Disclosure is for the sole purpose of facilitating the worker's return to work.

The Act places an obligation on workers who claim benefits to cooperate in any health care measures deemed appropriate by the WSIB Board. Failure to comply with this obligation may lead to the reduction or suspension of benefits for the period of non-compliance. Furthermore, such workers are obliged to submit to health examinations by health professionals selected by the Board or the employer. Health care professionals are required to furnish the Board with reports on workers who claim benefits.

Therefore, in Ontario, when a patient is treated for a compensable injury or illness, the worker must sign a consent form for the treating physician and the WSIB to release work capacity or work restriction information to the employer for the purpose of safe and early return to work.

I am not sure how New Brunswick treats functional information. Perhaps someone in the audience can comment, because once we resolve this issue, then the next key issue is how do we gather and communicate this information from the health care providers to the employer and the insurer.

### **3. New Information – New Tools**

#### **Accommodation**

Let me turn our attention to identifying the Round Table Project III—the third identified theme—that of the paradigm shift from disability and life, to ability and life: I want now to talk about two potential systems that could serve as a basis for further discussion and address the point that I made earlier—the need to uncouple medical information and functional information:

1. International Classification of Functioning; and
2. Work Disability Diagnosis Interview

#### **International Classification of Functioning**

I want to introduce you to the International Classification of Function, which belongs to the World Health Organization's family of international classifications. ICF classifies functioning and disability associated with health conditions. It is complementary to ICD 10, which gives users a framework for classification by diagnosis, of diseases. In Canada the ICD is used mainly to classify death. In the US insurers also use it for classification of diseases.

The ICF is relatively new and is a practical application that has yet to be fully developed. However, there exist possibilities for it to be used as a tool for communication amongst the stakeholders.

The ICF is named for its emphasis on health and functioning. It places the experience of a decrement of health into the normal experience and thus does not separate it into a new category.

The aims of ICF:

- To provide a scientific basis for consequences of health conditions
- To establish a common language to improve communications
- To permit comparison of data across:
  - countries
  - health care disciplines
  - services
  - time
- To provide a systematic coding scheme for health information systems

Let me discuss some of the foundations upon which the ICF is based:

- 1 Human functioning – not based on limitations or disability
- 2 Universality -- applicable to all people irrespective of health condition

- 3 Parity – does not differentiate mental versus physical disability so that discrimination is designed out
- 4 Neutrality – language neutral so that both the positive and negative aspects of functioning is captured
- 5 Integrative model -- not merely a medical or a social model
- 6 Environmental Factors – contextual factors are captured – these may range from attitudes to laws to practices

The challenge to this new approach is that at the present time it is too theoretical. It needs to have stakeholders come together to work on it and then adapt it.

The contact regarding the ICF is Diane Caulfeild at the Canadian Institute for Health Information (CIHI). Diane is looking for opportunities to work with organizations to see how the ICF can be adapted.

The second potential tool is:

### **Work Disability Diagnosis Interview (WODDI)**

This tool is called the Work Disability Diagnosis Interview or WODDI for short. It was developed by Dr. Patrick Loisel of Sherbrooke University. It is currently being implemented in the province of Quebec for back pain.

Evidence suggests that disability from back pain is multifactorial and that the present disease or medical focus should be replaced by a clinical structured interview.

A panel of experts was brought together in order to develop this structured interview. The experts included an orthopedic surgeon, ergonomists, an occupational therapist, an epidemiologist, occupational physicians and a biostatistician. The committee of experts chose a framework similar to the International Classification of Functioning.

Together, they reviewed the scientific literature of the predictors of disability. The categories were:

- Sociodemographic
- Work related
- Bio psycho social

In order to complement the WODDI, six well-validated, self-administered questionnaires were added. These were:

1. Psychological Distress Index
2. Work Adaptation
3. Oswestry Disability Back Index
4. Pain Numeric Rating Scale
5. Fear Avoidance Belief Questionnaire

## 6. Neck and Upper Limb Index

Three of the original tests have been replaced by updated versions.

The WODDI is presented in a notebook. The physician administers the physical and psychosocial parts. The other parts are administered by an OT and an administrative assistant. The OT and the physician meet after the interview to discuss the case and to reach a consensus as to which tests to use. From results of the test and interview, they plan the patient's rehabilitation, which specifically addresses the factors responsible for the disability. Because the WODDI has a clinical questionnaire that is designed to stimulate thinking, appropriate training of personnel is required. The test is time intensive requiring three to five hours to administer.

The results of Dr. Patrick Loisel's interdisciplinary model indicate that although the WODDI is not appropriate in early stages of acute injuries, there is significant cost benefit to the system if provided after 12 to 26 weeks.

From my own practice, I can provide an example of where system dysfunction occurs. One of my patients was receiving disability benefits from CPP. He was stabilized medically and able to function in daily activities. After 10 years of receiving benefits, CPP identified that he was medically fit and terminated his benefits. However, his employer had changed his business and my patient's skills were no longer applicable. He was not retrained to do the new job and the stress of the situation became too much for him to deal with. Eventually, he relapsed. In this case, the unintended effect of a good intention—a new rehabilitation strategy under CPP—destabilized my patient and undid all my good work as a physician.

## 4. Medical Information – Ethical Framework

### The Nature of Medical Information

#### Why is it important to maintain medical confidentiality?

There are very few areas of our lives where we would want greater control than over our health information. Health information forms the basis of good care. One study indicated that in 70% of cases where patients were off work for greater than 12 months, they were off because of wrong diagnosis. If people do not feel they can trust their caregivers, then they will start to hide information, and not comply with treatment.

Thus confidentiality is a prerequisite for trust. When we take someone into our confidence and tell someone about ourselves, we do so in the belief we can trust the person not to divulge personal health information to anyone else. This basic trust in the patient/physician relationship is slowly eroding; we all need to be careful that we do not let it slip too far.

Many professional organizations in other countries also have developed statements of confidentiality. Although the medical profession has always regulated itself, the medical profession is now being integrated into legislation, which brings us to a new concept called *verified trust*.

### **The Nature of Health Care Information and the Need for Privacy**

Health care information and the medical record include sensitive personal information that reveals some of the most intimate aspects of an individual's life. In addition to diagnostic and testing information, history of diseases and treatments and the patient's history of drug use, the medical record includes the details of a person's family history, genetic testing, family relationship, sexual behaviour, sexual orientation, substance abuse, testing for sexually transmitted diseases and even private thoughts and feelings that often come with confiding to a psychiatrist or during psychotherapy sessions. Subjective remarks about a patient's demeanor, character, and mental state are sometimes a part of the record. The provincial health insurance number or sometimes the social insurance number is often used as the identifier; the information may be easily accessible to someone else.

Most important, patients do not reveal information if they do not feel they have a physician's trust. It is the patient's history taking that permits better diagnosis and thus better treatments.

Health care information can influence decisions about an individual's access to credit, admission to educational institutions, and his or her ability to secure employment and obtain insurance. Inaccuracies in the information, or its improper disclosure, can deny an individual access to these basic necessities of life, and can threaten an individual's personal and financial well being. Additionally, disclosing to a doctor some aspect of one's physical or mental health can be embarrassing, and that disclosure could lead to loss of dignity, reputation, and autonomy.

At the same time, personal health information is a source of important data for bettering society's health. It is used for insurance reimbursement. The medical record contains information such as prescription drug use, treatment outcomes, and reason for and length of hospital stay. The use of accurate and comprehensive health care information can assist in monitoring quality control of health care delivery, which could lead to strategies for improvement by providing resources for medical research. The benefit of using health information for medical research, such as in cancer research, for public surveillance and allocation of resources, is well documented.

## How the Medical Profession Addresses the Issue of Confidentiality Prior to any Legislation *and* What guidance was and is there to address it?

In the medical profession, we have been complying with the privacy and confidential requirement from the time of Hippocrates, fourth century, B.C. I mentioned the Hippocratic Oath, which has to be taken by every physician before and on graduation from medical school. I will outline how physicians have managed this area of practice.

1. The Hippocratic Oath is one of the oldest binding documents in history. Written in antiquity, its principles are held sacred by doctors to this day: "treat the sick to the best of one's ability, preserve patient privacy, and teach the secrets of medicine to the next generation." "The Oath of Hippocrates," states the American Medical Association's Code of Medical Ethics (1996 edition), "has remained in Western civilization as an expression of ideal conduct for the physician." Students in medical schools are required to take the oath before or upon graduation. It says:

*"I swear to fulfill, to the best of my ability and judgment, this covenant:*

*Whatever things I see or hear concerning the life of men, in my attendance on the sick or even apart therefrom, which ought not to be noised abroad, I will keep silence thereon, counting such things to be as sacred secrets."*

2. The Code of Ethics of the **Canadian Medical Association on Privacy and Confidentiality (updated version)**:
  - Protect the right of our patients to control collection, use, disclosure of and access to their personal health information.
  - Inform your patients about the purposes for collection, use, disclosure and access to their personal health information at or before the time of collection, including the potential for such to occur nonconsensual; ensure that their information is accurately recorded and protected.
  - Ensure that measures are in place to protect the personal health information of your patients.
  - Disclose your patients' health information to third parties only with their consent, or as required by law, or when the maintenance of confidentiality would result in a significant risk of substantial harm to others or to the patient, if the patient is incompetent; in such cases, take all reasonable steps to inform the patient that confidentiality will be breached.

- When acting on behalf of a third party, take reasonable steps to ensure that the patient understands the nature and extent of your responsibility to the third party.
  - Upon a patient's request, provide the patient or a third party with a copy of his or her medical record, unless there is a compelling reason to believe that information contained in the record will result in substantial harm to the patient or others.
3. To further guide its members, in August 1998, the CMA council approved the **CMA Health Information Privacy Code**. The Code is founded on the belief that privacy is a right, and fundamental values in any society that aspires to be free and democratic. The Code is dedicated to the need to preserve and protect the sanctity of the doctor-patient relationship.

However, the Code also recognizes that health information may have beneficial uses for teaching, research and beyond those with therapeutic benefit to the patient. The Code clearly spells out under what circumstances these secondary purposes for use of health information may be permitted. The Code is based on a model developed by the **Canadian Standards Association** that articulates ten basic principles. Similar principles are articulated in **Schedule 1 of PIPEDA**. Therefore, the CMA Code, adopted in 1998, and Schedule 1 in PIPEDA are based on the same principles.

These principles are:

- The right to privacy
  - The special nature of health information
  - Limitation on the collection and use of health information
  - Specifying reasons for collecting health information
  - Consent
  - Individual access
  - Accurate recording of information
  - Security
  - Accountability
  - Transparency and openness.
4. The Code of Ethics of the **Occupational and Environmental Medical Association of Canada** (the national organization of occupational and environmental health physicians in Canada), includes the following:

**Respect the confidentiality of medical information**

- Treat as confidential whatever medical information is learned about the employee;
- Release such information only when it is mandated by law;
- Release information according to acceptable medical practice;

- Define, through a written policy, responsibility for custody and security of the medical records, and determine who will have access to them;
- Communicate your judgment to both the employer and the employee when the employee has undergone a medical assessment for fitness to perform a specific job;
- Provide the employer only relevant medical details or diagnosis when requested to do so in writing by the employee;
- Grant a request by an employee to release medical information to employer or others only if the request has been made without duress, specifies the nature of the information, the purpose for its release and the person to whom it may be released, and state the time for which it is valid.

## **How Personal Health Information Could Be Disclosed**

### **1. Patient requests – and the information the patients have a right to access**

Under PIPEDA (federal privacy legislation) and similar provincial privacy legislation, individuals have a right to access their own information that is collected by others about them.

Patients should have a right to information about the health care services available to them. It should be presented to them in a way they understand.

Patients also have a right to information about any condition or disease from which they are suffering. The information will include diagnosis, prognosis, treatment options, outcome of treatment, and common and/or serious side effects of treatment, likely time-scale of treatments and costs where relevant. This should also be presented in a way they understand.

It is also good practice to give patients information about the secondary uses of the health care information even though only anonymous information about them may be used to protect public health, to undertake research and audit, to teach or train medical staff and students and to plan and organize health care services.

However, the patient's general right of access to medical records is not absolute. In all the legislation, if the physician reasonably believes it is not in the patient's best interests to inspect the medical records, the physician may consider it necessary to deny access to the information. The onus lies on the physician to justify a denial of access. Patient should have access to their medical records in all but a small number of circumstances such as when there is significant likelihood of a substantial adverse effect on the patient's physical, mental or emotional health or harm to a third party.

## **2. Situations where information about patients is shared**

After the patient has given consent for treatment, express consent is not needed before any relevant personal information is shared to enable the treatment to be provided.

Patients should be aware that personal information about them would be shared within the health care team or “the circle of care” in Ontario.

Anyone to whom personal information is disclosed should understand that such information is given in confidence, which they must respect.

## **3. Disclosure of information other than for treatment of the individual patient**

Medical records are now being used for an increasing number of purposes. Medical records are widely shared with health insurance companies and government payers, and in some cases law enforcement agencies, welfare department, schools, researchers, and employers. PIPEDA specifies that prior consent needs not be obtained if information is divulged for medical research. The proposed Health Information Privacy Act in Ontario and some provincial legislation require the researcher to submit a proposal to a Board for evaluation, and the promise from the researcher to keep information confidential and to use the information only according to the proposal.

## **4. Disclosures which benefit patients indirectly**

These include the disclosures of personal health information for education, research, monitoring and epidemiology, public health surveillance, clinical audit, administration and planning. Professional organizations and government regulatory bodies which monitor the public health or the safety of medicines or devices, as well as cancer and other registries, rely on information from patients’ records for their effectiveness in safeguarding the public health. Law requires the notification of some communicable diseases, and in other cases, information could be reported anonymously if that is sufficient.

In occupational and environmental health practice, information on fitness to work is passed to employers to ensure that the job offered is suitable for the individual.

Express consent must be obtained where patients may be personally affected by the disclosure. Disclosure of personal information to a patient’s employer is one of these situations. Examples of this include independent medical examinations (IME) done on the worker or when the worker has to undergo random or alcohol testing. When seeking express consent, physicians must ensure that the patient is given enough information on which to base their decision, the reason for disclosure and the likely consequences of the disclosure. The physician should also explain what information will be disclosed and to whom it is given.

## 5. Mandatory reporting

In all provinces, physicians are mandated by law to report a list of communicable diseases and certain specific conditions such as child abuse, and elder abuse. They are also required to report when someone's medical condition make him/her unfit to drive. Workers' Compensation Acts in different provinces require physicians to report work-related illness and injuries to the compensation board.

For the prescribed medical surveillance programs under the Occupational Health and Safety Acts in Ontario, the physician who examines the worker is required to inform the employer whether the worker is fit, fit with limitation or unfit to work to continue holding a job with the potential of exposure to that specific designated substance for which he/she is examined, and to report to the Chief Physician of the Ministry of Labour if the worker has been assessed to be unfit to remain on the job due to exposure to the designated substance.

## 6. Ethical reporting

There may be cases in which, for reasons connected with the safety of individuals or of the public, the obligations *prima facie* imposed by the confidential relation may have to be superseded. If patient withholds consent, or consent cannot be obtained, it is only justifiable to disclose the information where the disclosure is essential to protect the patient, or someone else, from risk of death or serious harm.

For example, what is the proper course of action for a physician if their patient who is a crane operator or who holds another safety sensitive job and develops a seizure, but then does not give the doctor consent to disclose that information to their employer for fear that they might not be allowed to continue to perform that job? **The Canadian Medical Association** is of the opinion that the physician must place the public interest first. The courts, including the Supreme Court of Canada, place a great deal of credence on recommendations from professional organizations such as the CMA.

CMA issued the following statement as guidance for Ontario physicians:

“The physician must be aware of the risks to the patient, his or her coworkers or the public that could arise from the patient's condition or therapy. If the medical condition of the worker or the nature of the work performed is very likely to endanger the safety of others significantly, the physician must put the interest of the public before that of the patient. The CMA holds that legislation should be enacted in all jurisdictions to protect physicians in these circumstances.”

However, legislation does not exist in all provinces or territories to protect physicians from liability for reporting under such circumstances. For Ontario physicians, the **Ontario College of Physicians and Surgeons** states that the reporting of

conditions required by law does not constitute professional misconduct. However, it does not address physicians who report unsafe workers in the workplace. Such legislation is badly needed.

Let me return to the OMA policy.

## **THE OMA TIMELY RETURN TO WORK MODEL OF DISABILITY MANAGEMENT**

The OMA feels the new program should include the following understandings:

1. When the patient is off work due to sickness or injury, they would bring an employer's proposed return to work program to their physician.

Do employers provide physicians with this information?

2. Physician provides objective reports on impairment, medical restrictions, and other supporting advice to the employee.

This will be changed to say functional information.

3. Employer offers the employee a plan for returning to suitable work in a timely fashion.

Do employers offer a return to work plan?

In a survey soon to be published, this was the number one complaint of physicians.

Employees reported no modified work programs despite it being part of the legislation.

4. Employee and management have a primary responsibility to initiate a timely return to work that incorporates input from the physician.

Does management have a positive attitude to people with disabilities? Do they understand their needs; I mean from the top down to the front line supervisor?

5. Management control of "sick leave" abuse is through work place "culture" and timely return to work programs, not medical certification.

**This year the OMA will update its policy to reflect the changes that have occurred. All sectors need to be aware of the following:**

Do not think that this is going to solve the problem, it will not.

All stakeholders need to be involved.

Bill Wilkerson from the Business and Economic Round Table on Mental Health has recently developed guidelines for the Board of Directors.

Australia has shown the impact of social marketing on the reduction of back pain.

All these initiatives need to be coupled with a strategy for knowledge transfer and ongoing education for all parties as well as a strategy for holding accountable those who do not comply.

It is only through multi-stakeholder groups like this one that we will be able to learn to make the advancements that are required in this field.

To summarize:

What is it that employer's need in order to accommodate workers? They need a supportive culture, cooperative employees, and in complex cases they need functional information.

I have tried to address accommodation and the perception that medical confidentiality is a barrier to return to work. I believe that the way to remove the barrier is to uncouple medical diagnostic and treatment information from functional information.

Medical confidentiality is critical to the appropriate diagnosis and treatment that promotes good care and confidence in the unique relationship between physicians and patients. Functional information should not be confidential.

Thank you for listening.

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