The Structure and Process of Workers’ Compensation Systems and the Role of Doctors: A Comparison of Ontario and Québec

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Background This study sought to identify impacts of compensation system characteristics on doctors in Québec and Ontario.

Methods (i) Legal analysis; (ii) Qualitative methods applied to documentation and individual and group interviews with doctors (34) and other system participants (31); and (iii) Inter-jurisdictional transdisciplinary analysis involving cross-disciplinary comparative and integrative analysis of policy contexts, qualitative data, and the relationship between the two.

Results In both jurisdictions the compensation board controlled decisions on work-relatedness and doctors perceived the bureaucratic process negatively. Gatekeeping roles differed between jurisdictions both in initial adjudication and in dispute processes. Québec legislation gives greater weight to the opinion of the treating physician. These differences affected doctors’ experiences.

Conclusions Policy-makers should contextualize the sources of the “evidence” they rely on from intervention research because findings may reflect a system rather than an intervention effect. Researchers should consider policy contexts to both adequately design a study and interpret their results. Am. J. Ind. Med. © 2016 Wiley Periodicals, Inc.

KEY WORDS: workers’ compensation; doctors; system differences; law; gatekeeping

INTRODUCTION

Doctors play key roles in workers’ compensation (WC), because they treat injured workers (IW) and provide medical opinions necessary to the determination of eligibility and duration of benefits (gatekeeping). Doctors also influence the strategies undertaken to return workers to active participation in the labor market.

WC systems were the first social insurance systems in Canada, having emerged in the early twentieth century to replace the tort system. At the time, the proponents of WC systems in Canada, Meredith in Ontario [Ison, 1996], and Globensky in Québec [Lippel, 1986] felt that the adversarial nature of the tort system was not conducive to fruitful industrial relations. Québec’s initial statute was inspired by French law, and the current legislation, enacted in 1985, was strongly influenced by input from unions and employers, given the bi-partite nature of the Québec WC board (WCB), the Commission de la santé et de la sécurité du travail (CSST) [Lippel, 2013]. Ontario’s first legislation was crafted as an original Canadian model [Ison, 1996] and has evolved under the influence of workplace parties but with a stronger influence from governments [King, 2014]. Nonetheless,
many of the underpinnings of the two WC systems are similar.

No-fault WC systems and not-for-profit public WCBs mandated to collect premiums from employers and to adjudicate workers’ claims were put in place to eliminate adversarial relations between workers and their employers and provide fair compensation for those injured at work, regardless of fault. Access to no-fault compensation benefits depends on proof of causation and proof of injury or illness; compensation is payable during temporary periods of disability, or for permanent impairment. All these issues require medico-legal evidence, often provided by doctors.

While several studies have examined the workers’ perception of the compensation process [Kilgour et al., 2015b] only a few have specifically focused on the experience of doctors involved in compensation systems [Kosny et al., 2011; Murgatroyd et al., 2011; Kilgour et al., 2015c; Brijnath et al., 2016], or in sickness absence certification [Gerner and Alexanderson, 2009].

Professional and institutional locations frame a physician’s engagement in WC. General practitioners’ (GPs) roles differ from those of specialists, and types of specialties may explain variations in doctors’ practices and experiences when interacting with the systems. We refer to these as “professional locations.” “Institutional locations” refer to the organizational and accountability contexts in which the physicians perform their roles: for example, whether they treat patients, act as advisors to the WCB, provide reports for employers or workers, advise tribunals or participate in a public health network. Institutional location can shape interaction with IW and the WCB. It is also possible that certain physicians gravitate to locations in the compensation system that align with their philosophical orientation and practices, rather than having their beliefs shaped by their location in the system.

An overview of different WC systems helps to identify universal characteristics and distinctions [Ison, 1998; Lippel, 2012] that can then be considered in comparing experiences between jurisdictions, systems, and countries. These studies suggest that even similarly designed compensation systems, like WC systems operating in different Canadian provinces or different Australian states, may have major differences.

A systematic review of the return to work (RTW) literature examined the extent to which studies considered the characteristics of the compensation systems applicable in jurisdictions where their research was undertaken, and found that, overall, scientific literature fails to adequately report on compensation systems, a limitation the authors suggest undermines the applicability of findings to policy and practice [Clay et al., 2014].

While many of the issues described in the literature are similar in Québec and Ontario, subtle differences between the systems, particularly those governing the physicians’ gatekeeping roles, can differentially frame experiences. We undertook this study because our previous research suggested that IW in Québec often felt angered and stigmatised by their interactions with physicians [Lippel, 2007], a response less evident among IW in Ontario (Eakin and MacEachen, 1998, 2003; Howse, 2016). We wanted to study, the different roles and practices of doctors in the two systems to identify possible explanations of this apparent difference.

Key to the relationship between doctors and the compensation system is their “gatekeeping” role, in controlling and mediating access to system benefits and resources. Doctors’ medical evaluations are key in the determination of eligibility for benefits.

In this article, we examine gatekeeping roles in light of the different positioning and functioning of doctors within two jurisdictions. We aim to tease out the relationship between specific aspects of WC system design and the role, practices, and experience of doctors in different institutional and professional locations within the system.

METHODS

Our methodological approach drew on both law and the social sciences, engaging: (i) classical legal analysis; (ii) qualitative analysis; and (iii) inter-jurisdictional and trans-disciplinary comparative analysis.

Classical Legal Analysis

We first compared the role assigned to doctors in the two provinces’ WC systems. We studied legislation and policy shaping the WC process, and relevant case law and legal literature addressing the medico-legal processes. Although the focus was on systems in force at the time of the qualitative interviews, we also gathered historical information about regulatory changes made over previous years to contextualize the experience described by participants.

Qualitative Analysis

A variety of qualitative data generation and analysis methods were used, including the strategies of critical qualitative inquiry and constructivist discourse analysis [Alvesson and Skoldberg, 2009]. The study was based on data from interviews conducted in Québec and Ontario, and documentary data offering insight into the practices of doctors in WC and how they were understood by others in the system (e.g., administrative forms, professional guidelines, medical blogs). The interview data gathered between 2010 and 2014, came from individual and group interviews primarily with doctors, but also with WCB administrators and other health care and legal service providers connected to work injury. The study also included interview data from previous studies of the investigators that had direct relevance to doctors and WC systems.
Participants were recruited primarily through “theoretical sampling” strategies [Glaser and Strauss, 1967]. Participants and data sources were purposively selected to allow for exploration of previously known and new conceptual parameters of the problem (e.g., anticipating that the professional and institutional location of doctors might influence how they understood and did their work, we recruited participants with differing tasks, positions, and accountabilities in the compensation arena). We sought out individuals known (by the investigators or participants) to have differing experiences with the issues at hand, or who could cast light on the situation/perspective of doctors in locations not accessible to us. Sampling also reflected what we learned as the study progressed and our emerging needs for analytic comparison. Table I provides information on the participants interviewed individually or in groups.

Group interviews were organized by broad category (e.g., doctors, worker representatives, health care professionals). Most doctors interviewed had occupied more than one institutional location related to WC during their careers. All but one of the Québec interviews were in French (translated into English when used here).

All interviews were conducted in person using qualitative interview techniques [Gubrium et al., 2012] that guide participants to talk using questions formulated to not impose pre-conceived shape or content. Group interviews were conducted and interpreted with attention to the influence of group dynamics and interaction on the data. Most interviews were attended by two principal investigators, a productive methodological strategy that enhanced the quality of subsequent analytic triangulation. Data analysis involved deploying various analytic devices for deep interrogation and conceptualization of the data, including the constant comparison method [Glaser and Strauss, 1967], and critical reflexive interpretation [Alvesson and Skoldberg, 2009]. To maximize confidentiality this text camouflages some gender and particularizing details of the participants.

**Inter-Jurisdictional Transdisciplinary Analysis**

We developed a dialogue-based analytical approach, to capitalize on the researchers’ different disciplinary perspectives

<table>
<thead>
<tr>
<th>TABLE I. Interview Participants</th>
<th>Ontario</th>
<th>Québec</th>
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<tbody>
<tr>
<td>Number of doctors interviewed</td>
<td>Individual: 12</td>
<td>Individual: 10</td>
</tr>
<tr>
<td>(total 34)</td>
<td></td>
<td>Group: 12</td>
</tr>
<tr>
<td>Number of non-medical participants interviewed, individual, and group (total 31)</td>
<td>Seven health care providers</td>
<td>Ten worker or employer advocates (lawyers, union, or community group representatives)</td>
</tr>
<tr>
<td>Professional locations of doctors</td>
<td>Occupational medicine, family medicine, medical, and surgical specialties</td>
<td>Occupational medicine, medical, and surgical specialties</td>
</tr>
<tr>
<td>Institutional locations of doctors</td>
<td>Treating physicians (may include specialists) Consulting specialists IMEs and providers of written medical opinions for employers, the compensation board, workers, the Workers’ Safety and Insurance Appeal Tribunal, Doctors who had been employed at the WSIB</td>
<td>Treating physicians (may include specialists) Consulting specialists IMEs and providers of written medical opinions for employers, the compensation board or workers, Doctors who had played adjudicative or administrative roles within public institutions Doctors who testified in appeals Public health physicians</td>
</tr>
<tr>
<td>Secondary study data</td>
<td>Eakin et al., 2009’s study of 36 frontline compensation board adjudication and claims process workers in Ontario and other documentary data</td>
<td>Lippel, 2007’s study of 85 injured workers in Québec</td>
</tr>
</tbody>
</table>

*These included specialists from respirology, dermatology, physiatry, orthopaedics, ear nose, and throat; we aggregate information from both provinces to preserve confidentiality, here and elsewhere in Table I.
RESULTS

A classic legal analysis comparing the rules covering the two WC systems showed similarities but also key differences in the roles reserved for doctors. Analysis of interviewees’ experiences revealed similarities and differences in policy implementation that were not evident from a legal analysis alone. In Table II, we summarize key similarities and differences in the rules governing reporting and claims, and in Table III, we summarize dispute and appeal mechanisms in the systems of Québec [Cloutier and Tremblay, 2015; Dorval et al., 2016] and Ontario [Dee and Newhouse, 2015]. The CSST1 and the Workplace Safety and Insurance Board (WSIB) are the publicly run WC boards (WCBs) in Québec and Ontario, respectively.

System Similarities

System similarities of particular relevance to the role of doctors include: (i) decisions on work-relatedness were reserved for the WC adjudicators (supported by doctors affiliated with the WCB either internally or externally); (ii) the bureaucratic process of compensation was challenging for treating physicians (TPs), although in different ways in the two systems; and (iii) incentives and disincentives to treat IW were present in both systems.

Determination of work-relatedness

In both provinces the WCBs responsible for the implementation of the WC legislation have the last word on the determination of causation of the injury or illness. They also decide whether the functional limitations caused by the work-related condition are an impediment to return to the pre-injury job. Doctors’ opinions on causes of occupational disease, for example, are not ascribed any particular weight by the legislation itself, and the WCBs may set aside the TP’s opinion. In Ontario this is true of all opinions provided by physicians; in Québec, physicians’ opinions on some issues are “binding”2 on the WCB (Table II), and thus carry more weight than those of their Ontario counterparts.

Analysis suggests that the WCBs’ rationale for retaining control of the determination of work-relatedness is that doctors do not have particular expertise on working conditions. When asked about the possibility of physicians’ opinions being binding in Ontario, a senior WCB administrator was adamant that this was “almost unthinkable,” adding “we don’t have it, we haven’t had it, we would not recommend it” (WSIB1). However, this administrator conveyed that the core underlying concern for the WCB was the need to retain control over the determination of work-relatedness.

Doctors sometimes noted that the work-relatedness issue had implications for their relationships with others in the system. One company doctor in Ontario told us he deferred to the WSIB on work-relatedness and avoided taking a position, even if the company he worked for would have liked the claim to be denied.

This doctor thought that leaving work-relatedness up to the WCB facilitated his job and relationships with the various workplace parties with whom he has to interact.

I: Right, so they don’t press you to make a judgement on this and you’re able to step back?

P: Well, yeah ... it’s the relationship I have with my clients. [...] I have to be careful because I have to deal with the union, I have to deal with management, I have to deal with the employees so I am very guarded in terms of casting any doubt on an alleged work-related injury unless I am quite certain that it wasn’t work-related (ONDoc2).

Control over the determination of work-relatedness allows both WCBs to maintain at least partial control over claims. In Québec, because the CSST controls decisions regarding work-relatedness, the binding opinion of TPs regarding treatment plans is conditional on the acceptance of the initial claim for the specific diagnosis requiring treatment. The significance of the doctor not having a say in determining work-relatedness helps explain why, in Québec, legal participants perceive doctors as having considerable power within the WC system (because of the binding status of their opinions), while at the same time the doctors themselves often express a lack of power to affect outcomes for their patients (because they do not control the initial acceptance of a claim for a specific diagnosis).

Effects of the bureaucratic process

A second similarity between the Québec and Ontario systems is the significance for doctors of the bureaucratic process of WC, particularly the challenge of “paperwork.” Many doctors in both provinces saw administrative obligations to be problematic in their time-sensitive medical

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1 On January 1st, 2016, the Commission des normes, de l’équité, de la santé et de la sécurité du travail (CNESST) replaced the CSST.

2 On the WCB facilitated his job and relationships with the various workplace parties with whom he has to interact.
practices: “... a lot of family doctors are pushed for time so, you know, somebody comes in with a work injury, and you know, you’ve gotta do the paperwork ... we’re not necessarily enthusiastic about [that]” (ONDoc10). A Québec specialist spoke colorfully of the same issue: “Because there’s the little brown form, the little green form, primary care physicians are allergic to the forms... they must come out in hives just looking at them ... ” (QSpecPG).

In both systems, the role and input of doctors into the compensation process was framed and constrained by the nature of the forms themselves. In Ontario, the options available to the TP on some of the forms clearly circumscribed their ability to state opinions that are not wanted by the WCB. For instance, the “Health Professionals Progress Report” asks questions about residual capacity of a worker after the initial injury, specifying that: “Pain should not be the only medical restriction. Is there any other reason this worker cannot return to work at this time? Please provide details and expected return-to-work date.” Although worker representatives and some physicians acknowledged the role of forms in limiting the professional input of doctors, some doctors seemed unaware of how their participation was being controlled in this way, while others indicated that they found the restricted, tick-box nature of the forms to be time-saving.

In Québec, the space available to the TP to provide information on diagnosis, treatment and functional limitations was quite limited, a problem identified by IWs’ representatives who argued that it was a disincentive to provide details that could expedite evaluation of the claim. A specialist recounted that she had asked the CSST for additional information on filling in forms but received no assistance, and subsequently was called by an employer telling her that she had not filled out the form correctly—an experience she did not enjoy. As she put it, “it’s sort of bizarre when it’s the expert who doesn’t know how to fill in the form” (QDoc9). Another (QDoc8) noted that colleagues from his specialty find the form for assessing permanent disability and functional limitations so complicated that they do not want to fill it in, prompting them to refer their patients...
<table>
<thead>
<tr>
<th>Mechanisms/ procedures</th>
<th>Ontario</th>
<th>Québec¹</th>
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<tbody>
<tr>
<td>Right to dispute medical opinion of treating practitioner (TP)</td>
<td>WSIB may set it aside without any formal dispute process.</td>
<td>Employer or CSST, but not the worker, can dispute any of the five binding components.</td>
</tr>
<tr>
<td>Second medical opinion</td>
<td>WSIB or employer can request second opinion—worker can formally object.</td>
<td>Employer and CSST have the right to require the worker submit to a second medical evaluation after each opinion of the treating physician (after each form submitted).</td>
</tr>
<tr>
<td>Regional Evaluation Centres (RECs) and Specialty clinics funded by the WSIB may be called on to provide second opinions.</td>
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<td></td>
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<tr>
<td>Arbitration of conflicting opinions</td>
<td>No formal mechanism, however the WSIB can ask external service providers for medical opinions.</td>
<td>If treating physician does not agree with 2nd opinion, the Bureau d’évaluation médicale (BEM), a third doctor, provides a new opinion that is binding on all parties unless formally disputed. The worker, employer, or CSST can dispute BEM’s opinion. This process may be repeated many times in the same file.</td>
</tr>
<tr>
<td>Ongoing reporting</td>
<td>Form completed by treating practitioners at request of WSIB.</td>
<td>Forms must be filled in by the treating physician if anticipated duration exceeds 14 days or significant changes in the prognosis occur. CSST may request opinion at any time. Forms all go to the CSST that is obliged to provide a copy of each to the health professional designated by the employer.²</td>
</tr>
<tr>
<td>Return to work before maximum medical recovery</td>
<td>Health care provider may be required by employer or worker to fill in Optional Functional Abilities Form (FAF)²—no diagnostic information included.</td>
<td>Employer may (not required) propose modified work described by the employer in a prescribed form to be approved by the treating physician if (i) worker is reasonably fit to perform the work; (ii) the work, despite the worker’s injury, does not endanger his health, safety or physical well-being; and (iii) the work is beneficial to the worker’s rehabilitation.³</td>
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<tr>
<td></td>
<td>Employers and workers must cooperate in early return-to-work process, subject to fines or suspension of benefits.⁴</td>
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</tr>
<tr>
<td>Internal appeal (within the Board)</td>
<td>Treating practitioner obliged to submit form on ability to do modified work; functional abilities and treatment plan at the request of the WSIB.</td>
<td>Internal review, no hearing.</td>
</tr>
<tr>
<td>External appeal</td>
<td>Workplace Safety and Insurance Appeals Tribunal (WSIAT)⁵—has physicians on staff to assist tribunal; may pay for opinions from independent medical assessors who review the case in light of the literature and respond to questions from the Tribunal. Physicians or other health care providers may be called to testify on behalf of the worker or employer. Office of the Worker Adviser and Office of Employer Adviser report to Ministry of Labour but funded by the WSIB.⁶</td>
<td>Commission des lésions professionnelles (CLP)⁶ has physicians on staff who may assist tribunal and attend hearings. The CLP does not fund expert opinions from independent medical assessors.</td>
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</table>

¹ Dorval et al. [2016].
Compensation-related medical work had incentives as well as disincentives for doctors. Doctors in both provinces noted advantages of this work beyond the obvious reward of providing health care to patients. They suggested that access to treatment options is better when the WC claim is accepted, and there was agreement among interviewees that waiting times for physiotherapy or tests is reduced when the patient is covered. In Québec, one doctor said that there was an economic incentive to treat IW, as physicians had maximum earnings quotas under public health insurance, quotas that excluded earnings from WC, an issue that did not arise in Ontario.

Despite advantages for doctors and their work-injured patients, our data suggests that for many doctors the disadvantages of engaging in WC work predominated. Hence an important similarity between the two systems was a reluctance to take on this kind of medical work: “The frustration is with the bureaucratic side … the result of that might be that knowing that somebody is going to be Compensation, there, there might be some resistance to, to treating that particular person, not because of interaction [with them] but because you don’t want the hassle” (ONDoc1). Less delicately, in Québec we were shown a photograph of a roadside sign in front of a medical clinic, stating in large letters: “We don’t take CSST patients.”

Interviews with IW revealed that they themselves experience first-hand doctors’ aversion to compensation cases, “There’s not one who is willing to operate on me, you’ve got CSST written on your forehead, they don’t want to touch you. There’s a pile of forms to be filled in and they don’t want to touch that” (TA13).

**System Differences**

There were differences in the two compensation systems that had implications for doctors, the most striking being: (i) TPs played different roles in the initial adjudication process; and (ii) doctors participated differently in dispute processes.

**The role of TPs in initial adjudication of medico-legal issues**

Differences in the physician’s role in the early phases of compensation were evident in the processes of determining compensability and assigning “modified” work during active treatment.

**Determination of Compensability**

A first important system difference in the role and significance of the TP lies in the process of determining key issues underpinning compensability. As compared to Ontario, Québec legislation gives greater weight to the opinion of the TP.

**Québec: Binding Opinions and Accompanying Dispute Process**

In Québec, the TP provides an opinion on five issues defined by legislation: diagnosis, treatment, date of maximum medical recovery (MMR), functional limitations, and permanent impairment (Table II). Once the claim is accepted, these opinions are binding on the CSST unless it, or the employer, undertakes a formal dispute process.

Participants interviewed in Québec almost universally agreed upon the value of the primacy of the TP’s opinion, regardless of their professional or institutional location. It
was widely believed that the TP, because of ongoing contact with the worker, can best appreciate his condition as opposed to others who only have a snapshot of the worker on the day of the medical evaluation, or who might be using tables of average healing times rather than individualized knowledge of the patient.

The binding nature of the TPs’ opinions has implications for doctors. First, because the doctors’ opinion is provided through forms, the way they fill in those forms—most specifically the language and terms they use when providing diagnoses and prognoses—can have critical consequences for themselves as professionals, for workers’ claims, and the RTW process. For example, in terms of diagnosis, legal repercussions will differ depending on the term used. As explained in a textbook targeting doctors [Lippel et al., 2008], if the diagnosis is “lumbar sprain,” the injury will be presumed to be work-related if the worker was doing her job when the symptoms manifested. If instead the doctor writes “bad back” or “lumbago” on the form, this legislative presumption may not apply. Interviewees spoke of the heavy weight placed on the specific diagnosis. One specialist had seen claims rejected before she even saw the patient because the GP who had filled in the initial form had used a diagnostic term that was not on the closed list of acceptable diagnoses used by the non-medical CSST adjudicators determining eligibility. Some doctors felt the weight of responsibility with regard to the significance of their diagnostic language, and felt undertrained.

The binding nature of the TPs’ opinions increased the likelihood of formal disputes. Doctors, from a variety of locations, expressed difficulty with the contentious nature of the process. Many voiced, as did this specialist, a distaste for having their professional judgment questioned:

... the doctor is confronted, and he’s not used to that in his profession. When you see a patient [in a hospital setting] nobody is going to tell you what to do. [but in WC cases] another doctor is going to come along and criticize your work, in a really direct way ... so doctors who aren’t used to this, they find it really hard to take ... some young doctors have told us they don’t want to see any more injured workers because it is a system of confrontation (QSpecFG).

Employers, and the WCB, must follow a formal dispute process if they want to challenge the opinion of the TP. They frequently (no legally imposed limits) require that the worker be examined by an IME, who may be a GP. Non-compliance on the part of the worker can lead to suspension of benefits.

Treating specialists complained that the rigidity of the system made the initial TPs’ errors when completing the forms difficult to correct, which hobbled the specialists’ ability to provide the treatment they felt the patient required.

It’s very, very, very, problematic because we have to tell our patient ‘go back to your physician so he can tell the CSST he made a mistake because as long as he doesn’t change his opinion, you’ll have to contest his opinion, but you can’t.’ And the patient says ‘he doesn’t want to see me.’ And then we are in a no man’s land. We can’t do anything. And the patient is mad at his doctor who doesn’t want to see him. Tells us to do something. That’s the most pathetic case. [This type of problem] comes up rarely in non-CSST cases (QSpecFG).

This type of problem was said to arise in particular when the worker does not have an ongoing relationship with the TP who filled in the initial forms; many Québécois do not have family physicians.

Ontario: TPs’ Opinions May Be Set Aside Without Dispute

In Ontario, the WSIB is not obliged to comply with opinions of TPs. Accordingly, the data suggest that doctors are not as engaged in the WC system as they are in Québec, and their diagnoses and evaluation of functional abilities are less central to the adjudication process, although company doctors do seem to be active in the RTW process.

Without a binding effect of their decisions, there are fewer disputes involving doctors. Employers may request that a worker be examined by a physician of the employer’s choosing, but the WSIB retains the final word as to whether the worker need comply, and our data suggests that, in practice, Ontario employers do not regularly submit their employees to medical evaluations for WC.

Some non-physician health care providers believed that doctors’ opinions tended to prevail over their own assessments: “... the physician typically has the hammer. Yeah, you know, WSIB or the patient won’t make a move on that [functional abilities] without physician’s consent” (HCP2). Other evidence was more equivocal, as we see in an IW representative’s answer to a question about what he would change to improve the compensation system,

... that the treating doctor’s opinion is respected as a professional and not requiring that professional to say anything more than one sentence “This worker requires 12 weeks of physiotherapy” or “can work part-time”... They don’t need to write ... four pages explaining you know, justifying essentially their opinion and backing it up with all sorts of tests (WRepFG).

Implicit in this response is a view of doctors as having limited power in the system—their opinions are not authoritative without extensive elaboration and justification.
Doctors themselves expressed some sense of marginality within the system. Several reported not knowing if they were listened to or if their conclusions were accepted: “...sometimes I, I just feel that you know, they are asking my opinion, they are paying me for my opinion, and they are ignoring my opinion ...” (ONDoc10). Similarly, a company doctor seemed aware of his own lack of influence, observing that he does not pronounce on work-relatedness because, “... it doesn’t matter if I did say it wasn’t or was work-related, the Board is not going to adjudicate the claim based on me. They may consider something I have to say but I suspect really they were looking more into the form 8 and to the medical that’s provided” (ONDoc2).

**Assignment of Modified Work During the Active Treatment Period**

In Québec, (Table III), the TP, has the last word as to whether an IW can do modified work before MMR, and that decision cannot be disputed by either the WCB or the employer, although the employer can propose different modified work to the doctor if the initial proposal is refused. Because the TP’s opinion is final on this issue, we noted that other doctors connected to the system were less active in RTW processes before recovery was complete. Although doctors from all locations gave opinions about issues of compensability, there was no “market” for the provision of second opinions on issues related to RTW before MMR. No IME reports would be relevant, given the weight legislation ascribes to the opinion of the TP.

In contrast, in Ontario, physicians from several locations are active in the early RTW process, be they company doctors, WCB doctors or specialists in occupational medicine working in specialty clinics. The WSIB has the last word as to whether a worker can do modified work and the employer and worker are required by law to “cooperate” and can be penalized if they do not. If they disagree with the WSIB’s decision, they can dispute it, and can request opinions by IMEs and others with regard to the appropriate-ness of the work provided by the employer.

Some participants believed that WSIB disregarded the opinions of some TPs in Ontario, as this injured worker representative remarked,

> The doctor is supposed to check off little boxes, you know, can lift, you know, up to 5 pounds, 5 to 10 pounds ... There’s a space for other comments and often what you’ll find is a doctor will write there because there is no place else to write it: “can’t work at this time, needs time to heal.” Well, that will go to the Board, they will ignore those comments and only look at the functional ability boxes and send the person off to work. And the doctor is going, you know: “is my writing not clear enough?” and “they don’t care about that right?” So, he, the doctor he or she is complying with the form, checking off the boxes but their actual opinion you know, in, in terms of the medical status of the person, is not regarded (WRepFG).

Ontario doctors also sometimes felt that they were being second-guessed in their professional opinions. Here, a doctor notes his discomfort with the potential for too close scrutiny and negative assessment of his clinical judgment,

> [WC work] has very strong health professional oversight [long pause] you know, which I think is good and bad. . . . the tough part of it is I do feel like there’s probably someone at the other end very carefully picking through what I have written on that form, right? Which is a little bit nerve racking. . . . I often feel like it’s someone who has a lot more expertise in this than I do ... So, there’s a little more kind of tension filling out those forms for that reason (ONDoc5).

The binding nature of TPs’ opinions in Québec and not in Ontario may be linked to provincial variation in the engagement of other physicians in the RTW process before MMR. In Ontario, physician interview data suggested that the process of getting IWs back to work in modified jobs was particularly important to company doctors who saw their role in the early RTW process as essential. The salience of the doctors’ role in the Ontario RTW process was also evident in the concerns of WCB staff, one of whom referred to “fixing the doctors” with reference to improving their cooperation in RTW. In contrast, in Québec, confrontational involvement of doctors in assignment of modified work was much less apparent. We see, for example, a lawyer for employers advising clients that if they want the worker to come back to work before MMR, they would have more success if they could “Stop working on the doctor, work on your worker” (QEmpLaw). He argued that rather than focussing directly on getting the cooperation of the physician, they should focus on finding alternative work that the worker wants to do, which would make it much easier to get the approval of the TP.

**Role of physicians in the dispute resolution process**

Québec and Ontario differ from each other in terms of the physicians’ role in dispute resolution. Once the TP files the necessary forms, the WCB renders decisions that are based on the information provided; however, the mechanisms for questioning doctors’ opinions are quite different (Table III).
In Québec, TPs, be they family physicians or specialists, are subject to continual and explicit scrutiny by other doctors hired by the CSST or the employer to provide second opinions for the purpose of triggering the dispute process, which in turn leads to a third opinion from the BEM. The adversarial nature of this process was widely noted as a problem by our interviewees, although the second opinions provided by doctors appointed by the CSST and the BEM were said to have “improved” considerably in tone and quality over the previous 5 years.

Seen as unchanged, however, was the confrontational tone of the opinions of doctors paid by employers. Several study participants spoke of “certificats de complaisance” or written medical opinions given, in this case to employers, with content predetermined by the client rather than the doctor.

Some TPs expressed consternation at the critical and disrespectful tone of the opinion provided by the doctor paid by the employer to question their opinion, as expressed by a specialist:

“I’m not an expert physician . . . only a treating physician. As a treating physician I understand very well that there can be differing opinions with those of expert physicians [IMEs] but I find it very difficult when I read an expert opinion by a colleague from a different specialty that attacks us. That’s a lack of professionalism and often the patient has read that opinion and it creates a malaise because the patient is stuck in the middle; so disagreement is one thing, but lacking professionalism and attacking the other, that’s something else. Written in bold and underlined, you know, that shouldn’t exist and it creates a malaise that’s so unnecessary” (QSpecFG).

This specialist did not consider herself to be an “expert” because she does not provide “expertises” (French term for IME reports). Other specialists spontaneously denied being “experts,” both because they were not specialized in producing documentation for purposes of litigation, and, in one case, because she did not consider herself sufficiently grounded in issues of work-relatedness. The confrontational underpinnings of the Québec process thus appeared to affect the way specialists perceived themselves, a finding that did not emerge from the Ontario data.

In Québec, we were told of the emergence of large service providers for employers, staffed by doctors, many of them GPs, whose services included the provision of “expertises” for litigation purposes. One respondent referred to these service providers as medical “multinationals,” explaining that equivalent medical services were not available to unions or workers. We were told that doctors testifying for workers were sometimes perceived as less credible: because so few would provide expert opinions for workers, the same doctors testified frequently.

The role of physicians in disputes is decidedly different in Ontario where the medico-legal evaluation process has evolved over the years. Historically, the WSIB’s team of physicians provided oversight of medical opinions, but in recent years the WCB has externalized this work, in part because the former in-house physicians were perceived, at least according to one key informant, as a “lightning rod” for worker anger with the WCB. By outsourcing this function, the WCB has created a new role for physicians, that of external consultant performing “piecework” evaluation of files, typically without face-to-face examination of workers.

Several organizations have ongoing institutional-level contractual relationships and interactions with WCB staff. The Regional Evaluation Centres (RECs) and the Specialty Clinics (e.g., hand, chronic pain, occupational disease) have no counterpart in Québec (Table III). In Ontario, forms are submitted by TPs, but the WCB may require workers be seen by other physicians in either a REC or Specialty Clinic and workers who do not comply jeopardize their benefits. There was some evidence that RECs were perceived as money-saving devices that “bypass” the TPs.

Take a look at the [ABC] REC and their boast “Almost 100 percent return-to-work for all conditions!” Look carefully: recovery is defined as actual return-to-work or ‘being declared fit to work.’ No follow up exists to see what really happens but the stats look great! And the WSIB actually boasts that it heals injured workers better than ever before; . . . but that is a tangent. The struggling hospital system gets money from the WSIB assessment centres. Good. But at the expense of injured workers and bypassing the treating doctors (ONWRRep).

This scepticism was also evident in the widely expressed view that IW who were referred to these RECs were uniformly told, regardless of their individual condition, that they could return to work within 4–6 weeks. However, some family doctors who felt they had insufficient training or knowledge to properly assess or validate workers’ claims appreciated the existence of these centres. “And at that point that’s when I think it’s a good idea for them to see an assessment center where the WSIB has maybe more confidence in the opinion of the people who are seeing them . . . ” (ONDoc10). This GP seemed to feel the WSIB had less confidence in GPs’ assessments than they did in those issuing from the REC. However, she went on to support the claims of worker representatives who believed such referrals were not individually tailored assessments of the patients, “they felt that he could go back to work after 6 more weeks of physio or something, which
didn’t happen and probably couldn’t happen based on this patient but ... at that point it’s basically over so this patient never did go back to work . . . ” (ONDoc10).

The review and appeal process in Ontario appears far less likely to involve the active participation of doctors, at least in terms of actual testimony. While doctors, either internal to the WSIB or acting as external consultants, provide written documentation that becomes part of the file on appeal, we rarely heard about multiple doctors testifying in an appeal case at the WSIAT. There are almost six times as many appeals to the CLP than there are appeals to the WSIAT, and a far greater proportion of the appeals relate to medico-legal debates between experts in Québec, as compared to Ontario (Table IV). Many of the interviewees in Québec discussed appeals at length while they were rarely addressed in Ontario. Given that the figures on medical evaluations shown in Table IV exclude half the appeals in Québec, which are settled in the formal conciliation process and thus are unavailable for analysis, while there is no formal conciliation process in Ontario, it is clear that medico-legal disputes are more prevalent in Québec, and the majority of medical arbitrations are triggered by employers (Table IV).

**Gatekeeping in Both Provinces**

Having reviewed results reflecting similarities and differences between the provinces we now focus briefly on further findings explicitly relevant for physicians’ gatekeeping roles, both as TPs (1) and as IMEs (2).

**Gatekeeping and treating physicians**

In both Ontario and Québec, TPs can be understood to be “gatekeepers” to entry into the system. Doctors themselves acknowledged this role, and many found it troublesome, referring to “médecins de traffic,” or “police doctors” and noting that it is a source of conflict with their patients, with colleagues, and with the WCBs. Others noted the tensions between the gatekeeping role and patient advocacy, resisting, or rejecting such roles as incompatible with the doctor’s professional and moral responsibilities. Reflecting on this tension, one doctor said, “What I try and do is just stay fair and objective um, you know, I am not supporting any position, I am trying to support the health of the individual” (ONDoc7). Others remarked: “the doctors are being trained to think of themselves as, as that their obligation is to the 3rd party payer and not to the patient” (QDoc3) and “... where the doctor is obliged to rat on his patients, so to speak, is an uncomfortable position for most doctors” (QDoc1).

In Québec, where doctors’ gatekeeping roles are highly structured by the WC regulator and the College of Physicians and Surgeons, communication between doctors and the WCB is complex and politically charged. The CSST can be criticized for contacting TPs, because it is not supposed to influence their practice and recommendations outside the formal dispute process, and a TP is often discouraged from contacting the CSST.

In some instances the structures of gatekeeping can lead to an artificial rigidity, where all parties realize something should be done to help the worker, but no one is willing to go beyond the mechanisms prescribed by law. One Québec TP described a case in which he had grave concerns for the wellbeing of an IW perceived to be at risk for suicide. He hesitated to call the adjudicator, but, emphasizing this was the only time he had ever done so, he eventually contacted her to share his concerns and seek advice:

> The adjudicator said to me “I’m glad you called, I know [the worker is] suicidal. [...] I’m glad because I am bound, so long as the doctor doesn’t write a referral to a psychologist on the paper, until then I can’t do anything.” I said, “Perfect, tell me what I need to write.” [...] You know, he’s suicidal, we can’t leave him wandering around, and I say to myself ‘there are so many frustrations on all sides,

**TABLE IV.** Number of Claims, Medical Arbitrations And Appeals to External Appeal Tribunal in Ontario and Québec 2014

<table>
<thead>
<tr>
<th>Claims/disputes</th>
<th>Ontario</th>
<th>Québec</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of lost time claims in 2013&lt;sup&gt;a&lt;/sup&gt;</td>
<td>54,430</td>
<td>67,687</td>
</tr>
<tr>
<td>Number of arbitrations triggered by second opinions (yearly average 2010–2013)</td>
<td>N/A</td>
<td>10,167 (6,976 initiated by employers, 3,191 by the CSST)&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
<tr>
<td>Number of new appeals to final tribunal in 2013–2014</td>
<td>5,079&lt;sup&gt;c&lt;/sup&gt;</td>
<td>30,026&lt;sup&gt;d&lt;/sup&gt;</td>
</tr>
<tr>
<td>Number of appeal decisions published (2010–2014)&lt;sup&gt;e&lt;/sup&gt;</td>
<td>14,292</td>
<td>40,422</td>
</tr>
<tr>
<td>Number of appeal decisions discussing “medical evaluations”</td>
<td>6,318 (44%)</td>
<td>23,906 (59%)</td>
</tr>
</tbody>
</table>


<sup>b</sup> UTTAM [2013b].


<sup>e</sup> Published decisions on tribunal search engines (WSIAT and AZIMUT-CLP).
the situation escalates, and if we could only just pick up the phone and say “don’t consolidate [Québec legal term for MMR] him because we’re going to have a problem otherwise” (QSpecFG).

Yet the same doctor agreed with other participants in the group interview that there were reasons for the firewall between TPs and the CSST, “The CSST is a big machine and sometimes you say to yourself “Some will do anything to trap the patient,” and I say to myself “Oh my God, I’ve sent him directly into the trap’ I don’t know where all the traps are” (QSpecFG).

In contrast, in Ontario, the power of the WSIB is not similarly constrained, and many participants described cases in which it set aside the opinion of the TP, or of other medical practitioners involved in the evaluation of the claim.

The different characteristics of the gatekeeping roles in the two provinces thus lead to different dynamics between physicians and the WCBs that have repercussions both for treatment of patients and outcomes of their claims. Policies and mechanisms designed to maintain the independence of physicians in Québec limit communication between the CSST and the doctors, which can create problems. On the other hand, when the WSIB has the ability to exercise power over physicians, this too can be problematic.

As we have seen, form filling is central to doctors’ gatekeeping role. Several participants in our study described this role as an irritant. One key informant, a spokesperson for a regulator in Québec responsible for oversight of physician’s professional obligations (QDoc10), was adamant that the gatekeeping role reserved for physicians in a broad range of contexts, including WC, was undermining society’s ability to provide access to medical practitioners, and undermining doctors’ ability to practice medicine, estimating that “gatekeeping” took up 30% of GPs’ time.

**Gatekeeping, IMEs, and medical advisors to boards and employers**

When doctors are paid to provide opinions to WCBs and employers their gatekeeping role is quite different from that of TPs. For physicians not treating patients, some gatekeeping activities can provide a significant source of income. One Québec doctor, who had abandoned his practice to work full time producing “expertises” for various public and private insurers and employers, remarked that this type of work was extremely lucrative as compared to what he was earning before as a specialist. He said many of his colleagues produced IME reports to ensure themselves a better pension, and concluded that it was “a bit scandalous to see how much they were paid for producing a report as compared to the remuneration for the labor of working in an emergency room all day treating patients” (QDoc1). While this issue arose in most of the Québec interviews, it was only occasionally raised in Ontario.

Many doctors in both systems spoke passionately of their work as gatekeepers in the WC system. Some said they love their work, and feel they are making a difference, be it in helping patients or saving money for the system. Several spoke of enjoying the “detective work” involved, although the meaning of that detection varied. For example, one specialist liked the detective work of figuring out what was making the worker ill, while another whose practice was primarily devoted to the production of IME reports for employers, saw himself as a detective whose mandate was to figure out the flaw in the reasoning that had led to the acceptance of a claim.

The role of in-house doctors in Québec, who were criticized for being “paper doctors” because they never saw the workers [Lefebvre, 1987], was marginalized by the 1985 legislative reform that led to the current system. The new system replaced in-house doctors with a variety of external medical evaluators, highly visible to workers who are examined by them. These evaluators are still criticized by IW advocates, who would prefer that the TP have the last word, without oversight by other medical gatekeepers [UTTAM, 2013a].

In contrast, the gatekeeping role of physicians in Ontario is less visible to workers. Traditionally, the WSIB had physicians on staff providing advice to the adjudicators related to medical and recovery issues. In recent years, the WSIB replaced its in-house physicians with physician-consultants working for external service providers who review files for the WSIB without examining the worker. Recently, a doctor working for one of these service providers, who was previously an in-house doctor at the WSIB, launched a lawsuit for wrongful dismissal against the WSIB and her employer, alleging that the WSIB threatened to end its service contract with her employer if her opinion concerning a specific worker was not modified to better suit them [Gallant, 2015; Steinnagel, 2016]. Other health care professionals have also denounced interference of the WSIB with medical care and have called for the elimination of “paper doctors.” a position made public by unions and IWs’ groups in Ontario [Ontario Federation of Labour, 2015]. Medico-legal evaluation thus remains controversial in both jurisdictions.

**DISCUSSION**

Our study contributes to knowledge on the importance of considering the design and characteristics of specific compensation systems when trying to understand: (i) access to healthcare for IW; (ii) the significance of professional and institutional location of doctors in relation to IW; and (iii) doctors’ interaction with IW.
Workers’ Compensation: Access to Doctors and Treatment Options

Our study confirmed that doctors may be reticent to treat IW because of bureaucratic requirements associated with WC procedures and because their role is exposed to scrutiny by various institutional actors. There were also advantages, in terms of treatment options available for IW as compared to other patients whose care was funded by the public health care system and, in Québec, some identified economic advantages for doctors in treating IW.

Several studies have found that access to healthcare for IW may be negatively affected by physician aversion to the gatekeeping role [Ison, 1986; Lax and Manetti, 2001; Lippel, 2007; MacEachen et al., 2010; Kilgour et al., 2015b,c], including bureaucratic requirements [Kosny et al., 2011; Kilgour et al., 2015c] and increased scrutiny [MacEachen et al., 2010], that sometimes affects their treatment choices because of the need to provide “objective findings” [Ison, 1986; Lax, 2000]. A study of Ontario doctors treating patients covered by WC found they resented the time required to complete the forms, the repeated requests for more and more precise evaluations and being ignored after providing advice on treatment or functional abilities [MacEachen et al., 2010], findings confirmed in our study.

Studies looking at sickness certification in the UK have found that TPs disliked the gatekeeping role because they felt scrutinized by other players in the system [Hussey et al., 2004; Higgins et al., 2014]. A Swedish study found that physicians feel threatened by the sickness certification process, both in terms of resistance from patients and fears of unwanted institutional oversight [Swartling et al., 2007]. Our study confirmed TPs’ dislike of being criticized or second-guessed by other doctors or institutions, but was less clear about the issue of resistance from patients.

The existence of a broader range of treatment options for IWs has previously been noted in Canadian [Hurley et al., 2008a,b] and American [Herbert et al., 1999; Hamm et al., 2007] compensation literature, although in Canada access to hospitalization and medical treatment is covered by the public healthcare system regardless of WC eligibility.

Our findings about the compensation system’s remuneration for services provided by TPs were more nuanced than those found in other studies [Kilgour et al., 2015b]. Our study suggests that the monetary incentive varies depending on the local regulatory context. In Québec, although the rates paid for treating an injured worker are not generous, some participants suggested that treating them provides monetary benefits by offsetting the reimbursement ceilings set under general public health insurance; no such incentive exists in Ontario.

Beyond individual doctors’ dislike of form-filling, in our study a Québec regulator expressed grave concern for the impact on the health care system of the multiple gatekeeping roles filled by GPs. Similar concerns were expressed in an article by the Chief Economist for the Ontario Medical Association who estimated that 20% of physicians’ time was spent filling in forms rather than treating patients [Kralj, 2008]. Furthermore, as others have noted [Thompson, 2007], if doctors do not want to treat IW, this has negative effects not only on their access to health care, it also contributes to underreporting of occupational injury.

The Importance of Considering Professional and Institutional Locations in Our Understanding of Doctors, Gatekeeping, and Workers’ Compensation Systems

The literature on “gatekeeping” in WC and sickness insurance systems focuses on the role of doctors from various institutional and professional locations in the determination of access to benefits, and in RTW processes. Lax et al. [2004] showed that doctors working for insurers, IMEs, provide more conservative opinions regarding work-relatedness and level of disability than do TPs, differences the authors attribute to perspective rather than skill or training. A training manual for IMEs suggests that their role is similar to that of the police or private investigators [Forcier and Lacerte, 2006], an approach shared by some of the IMEs interviewed in our study. Several studies have found that IME examinations were a source of stress for workers, sometimes with negative health consequences [Kilgour et al., 2015a,b,c] and stigmatisation [Lippel, 2007], which could explain why, in our study, the IMEs reported more tense relations with workers than did the other doctors interviewed. Draper’s work on company doctors suggests that working for a corporate employer colors the way a physician approaches medical practice [Draper, 2003, 2008], a position criticized by some occupational physicians [Guidotti, 2008]. We found that the institutional and professional locations of the doctors determined their positioning in relation to the workers they examined or treated.

The literature on disability management has produced many studies on the role of doctors in early RTW before MMR [Deyo, 1988; Cheadle et al., 1999; Dasinger et al., 2001; Reynolds et al., 2006]. These examine how TPs or occupational physicians and insurance physicians reason in their gatekeeping role [Meershoek et al., 2007], or how GPs can be mobilized to return workers to employment more quickly. Some studies propose strategies aimed at assisting physicians in their disability management role [Durand et al., 2002; Russell et al., 2005; Coutu et al., 2012; Werner et al., 2012; Hulshof and Pransky, 2013]. Others, while acknowledging the importance of increasing physicians’ remuneration for their role in RTW management, recommend reducing the role played by physicians, giving more weight
to the workplace parties, and relying more heavily on guidelines designed to limit physicians’ discretion [Reynolds et al., 2006] or on promoting better communication between physicians and employers [Kosny et al., 2015]. A study of employers’ perceptions of GPs in Australia found that they were “suspicious of the doctor patient relationship,” sometimes sought to choose the TP on behalf of a worker, and felt employers should have more interaction with TPs, including receiving clear information on diagnosis. That study reports that all employers interviewed used “malingering” labels and that “they struggle to engage with GPs and feel excluded from the process they want to be part of” [Kosny et al., 2015].

The Importance of Considering Systems in Understanding Doctors' Role in Workers' Compensation

In light of our findings regarding workers’ perceptions of doctors in previous studies based in Québec (Lippel, 2007) and Ontario (Eakin and MacEachen, 1998, 2003; Howse, 2016), we wanted to study the different roles and practices of doctors in the two systems to identify possible explanations of this apparent difference, an approach encouraged by recent literature on the importance of system design [Clay et al., 2014].

One explanation of this apparent difference is the variation in doctors’ gatekeeping roles. Workers in Ontario are less likely to have face-to-face contact with medical gatekeepers, particularly IMEs, as compared to their Québec counterparts, providing empirical evidence of how system design can influence the experience of participants in the system, a point that has been examined more generally in the literature. We found, as did Grant and Studdert, that “intensity of use of medical experts within cases may differ widely across jurisdictions” [Grant and Studdert, 2013].

As we have seen, gatekeeping roles with regard to early RTW are fundamentally different in the two systems. Because in Québec the opinion of the TP regarding RTW before MMR cannot be legally disputed or second-guessed, they are less often confronted; no one interviewed suggested Québec doctors needed to be “fixed” as in Ontario.

The Québec system creates a firewall between the WCB and the TP; the Ontario system allows for greater interaction between the WCB and all physicians participating in the system, and gives the WCB final say. While the firewall may often lead to formalistic confrontation of the TPs in Québec, opinions of doctors in Ontario are more easily overridden, which also leads to confrontation if they resist being ignored or pressured [Gallant, 2015]. It may be true, as some have said, that removing the gatekeeping role from TPs would provide a more business-friendly evaluation process [Higgins et al., 2014]; however, our study suggests that they are the best situated to provide accurate knowledge about the worker’s injury and residual abilities.

Much research draws on statistics from insurance systems, sometimes in comparative studies. In light of broad variation between categories of compensation systems, it is necessary to contextualize research when interpreting results. For example, findings on disability duration in studies undertaken in countries where coverage is available regardless of the cause of the disability must be interpreted in light of that context, as all types of disability will be compensated, which will potentially affect the duration of benefits [Anema et al., 2013; Lippel and Lötters, 2013]. A study comparing disability outcomes in six countries found that countries where systems were less stringent in the requirement of “sick notes” had lower levels of disability duration for the same type of health problem [Anema et al., 2009].

Strengths and Weaknesses

By linking qualitative methods and regulatory analysis in our study, we have been able to illuminate the importance of details and actual processes in a system that can determine doctors’ interactions with the respective compensation systems and the patients involved in those systems. This finding informs the literature on treatment of IW, on doctors’ participation in RTW processes, and on the management of doctors in compensation systems. However, our study focuses on WC systems in two jurisdictions, and conclusions as to specific system effects on doctors’ roles cannot be generalized to other systems or jurisdictions.

CONCLUSION

Our study was triggered by our informal observation of an apparent difference in experiences of workers in Québec and Ontario with regard to doctors. Findings suggest that an explanation lies in their different roles in these two systems. In Québec, where doctors have considerable power, workers might be more likely to target doctors with their anger and sense of injustice. In Ontario, where the participation of doctors is less visible and consequential for IW, workers may direct their discontent more to the WSIB. Québec workers are examined by multiple doctors, mostly not for treatment purposes. In Ontario, patients are less often seen by doctors for non-treatment evaluation, and are likely unaware of the evaluative process taking place that is based on information in their files rather than on medical examinations. The distinct roles played by physicians in Québec and Ontario with regard to RTW prior to MMR illustrates why it is essential to understand a system before designing interventions. We saw that TPs had the last word in assignment of modified work during recovery in Québec, while TPs in...
Ontario provided information on functional abilities, but had no binding say on the appropriateness of the alternative work provided. The Ontario system is much aligned with the dominant discourse in the RTW literature, that seeks to marshal TPs to promote more effective “disability management.” As we have seen, Québec TPs appear to be less likely to be overtly pressured to return a worker to employment before MMR, and employers wishing to provide modified work in Québec are encouraged to seek buy-in from the worker.

We also found that TPs in Québec are overtly confronted about their opinions, specifically with regard to issues that may be disputed before a tribunal. In Ontario, in the absence of a formal and multi-layered system of disputing medical opinions, physicians did not feel attacked in such an explicit way, although some clearly did not appreciate having their professional expertise ignored or criticised. We conclude that differences in system design affect the role, practices, and experiences of the doctors in the systems. Issues that can be the object of medico-legal dispute determine the market for medical consultants and IMEs, which in turn determines the degree of scrutiny, and potentially the degree of confrontation to which TPs are exposed. Although the rules of the system drive the behavior, few of those interviewed seemed to be aware of the triggers of their experience.

Our study has implications for policy-makers, researchers and practitioners, both in medicine and in law. Policy-makers who use intervention research to develop policy need to contextualize the sources of the “evidence” they rely on to inform their own institutional policy, as findings in any given jurisdiction may reflect a system effect rather than the effect of the actual intervention. Researchers need to master the policy context in which they are undertaking a study both to design it and to interpret results. Physicians, be they TPs or IME providers, could be more effective if they had access to information and training regarding the systems they are working in and their roles in those systems. Physicians dealing with WC might benefit from greater understanding of the effect of their own practices on the compensation process, the experiences of their colleagues and, ultimately, on the health of workers.

AUTHORS’ CONTRIBUTIONS

All the authors declare that they have made substantial contributions to the conception and design of the study and of this article, have participated in the acquisition, analysis, and interpretation of the data discussed in this article, have participated in the drafting and critical revision of this article and have finally approved the version submitted for publication. All authors agree to be accountable for all aspects of the work.

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ETHICS APPROVAL AND INFORMED CONSENT

Ethics approval was obtained from the Ethics Review Board of the University of Ottawa and the Ethics Review Board of the University of Toronto. All participants signed written consent forms.

DISCLOSURE (AUTHORS)

None of the authors have any conflict of interest to declare.

DISCLOSURE BY AJIM EDITOR OF RECORD

Steven Markowitz declares that he has no conflict of interest in the review and publication decision regarding this article.

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Institution at which work was performed: The research was performed at the University of Ottawa and the University of Toronto.