Vocational Rehabilitation of Injured Workers Downsview: A Rehabilitation Center?

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INTRODUCTION

Legal caseworkers hear complaints from injured workers emerging into the following pattern with disturbing regularity. The workers' benefits have been reduced or terminated following an admission to the Downsview Rehabilitation Center (hereinafter called Downsview). The Board's doctor has declared that the worker is fit to work, contrary to the opinion of the worker's own specialist and/or family doctor and despite the worker's stated inability. Vocational rehabilitation was unsatisfactory because medical rehabilitation failed to alleviate the worker's pain or disability, or was initiated too late to help the worker. The worker is jobless, penniless and disabled.

The worker views his dilemma as immediate and primarily economic. The legal caseworker will focus on the medical disability of the worker when appealing the worker's claim. The real issue is a social one, of human dignity and fairness, of a workers' compensation scheme accepting financial responsibility for all injured workers.

The worker compensation scheme is a legislative creation and by its definition is a combined health and compensation plan for injured workers. There are three players in determining the manner of administering the plan: the legislature, the Workers' Compensation Board (hereinafter called the W.C.B.), and participating medical and rehabilitation practitioners. The scheme is in dire need of reform to bring the W.C.B. and health care policies and practices into line.

Downsview exemplifies the policies which undermine the W.C.B. Downsview epitomizes the practice of "policy" medicine/rehabilitation, the primary function of which is benefit control. To
Illustrate the problems with Downsview and with the W.C.B. policy statements concerning workers' rights and rehabilitation; Downsview, as an enforcing arm of the W.C.B.'s policies demonstrating significant unstated, underlying policy considerations, will be examined.

It is argued that injured workers bear an unnecessarily heavy social burden because the legislation fails to direct the W.C.B. policies to ensure that "effective rehabilitation" is the worker returning to the pre-accident status. It is further submitted that Downsview is a reflection of present W.C.B. policies which demand immediate review and is an expensive means of benefit control, an ineffective means of rehabilitating workers, and should be closed down.

Using the example of workers with back pain to illustrate the issues, this paper is intended to make two points: that the practice of medicine and rehabilitation at Downsview is based more upon the W.C.B.'s policies than it is upon the individual requirements of injured workers; and that the role of the health practitioners at Downsview in benefit control is harmful to the patient/health practitioner relationship and deleterious to the health and rehabilitation of injured workers. This paper also argues that real change in the W.C.B. rehabilitation system will only come about with legislative change which clearly spells out the philosophical basis for the system and the workers' rights.

The sources of information for this paper include conversations with former staff members at Downsview; conversations with injured worker clients from several legal clinics in the Toronto, Ontario area; and the author's own experiences as a physiotherapist, having visited Downsview on several occasions and taken courses there, and as a law student at Parkdale Community Legal Services in Toronto, representing injured worker clients.

BACK INJURIES: AN EXAMPLE OF THE W.C.B.'S PROBLEMS

The basic flaws within the W.C.B. bureaucracy and the medical scheme can be more easily understood by example. The population of injured workers with pain secondary to back problems were chosen as the focus of this paper because their plight very accurately reflects that of too many injured workers: disabled, unemployed, disentitled, and deserted. Specifically:

1. they are the largest identifiable group whose primary complaint is disabling pain and whose functional limitations are often not accompanied by proportionate, easily observable or measurable clinical findings;
2. they reflect the profile of the workers frequently admitted to Downsview Rehabilitation Center;

3. they have great difficulty in securing jobs because of the natural history of their injury; periods of being relatively symptom-free interspersed with bouts of pain;

4. they well illustrate the injured workers' complaints of medical and financial desertion by health care providers and a workers compensation plan, both of which promised to assist them to return to health and to work; and

5. they reflect the profile of the workers frequently seeking assistance of caseworkers who represent injured workers.

W.C.B.'S STATISTICS ON SERVICE

Health costs and service demands are soaring. According to the Workers' Compensation Board Annual Report, 1985, $146,302,809 was paid for health care benefits in that year, an increase of 13.6% over 1984. This cost represented over 3,704,408 "service items", an increase of 31.6% from 1984. Full-treatment programs for 9,438 injured workers were completed at Downsview in 1985, up almost 36% from 1984.1

The total number of work related accidents reported in 1985 was 426,880.2 Of the 174,063 total temporary claims settled, 48,988 or 28.1% were back injuries, while 29.9% or 2,478 of the 8,294 permanent disability claims were back injuries.3 Assuming the same frequency, back-related incidents reported in 1985 exceeded 120,000. The surveyed occupational and physical therapists at Downsview estimated that workers with back injuries represented up to 65% of their caseload. The Spitzer Commission reported that over 40% of all physiotherapy treatments in Quebec were for conditions related to the spinal column.4

Therefore, back injuries comprise not only a substantial proportion of all accidents and permanent disabilities, but substantial financial/human resources are devoted to their treatment. These two factors make back injuries a source of fiscal interest to the W.C. B. scheme. However, the high proportion of disgruntled and unemployed workers with back injuries, seeking advice at community legal clinics, indicates the need to review the efficacy of rehabilitation for these workers.

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2 Ibid. at 1.
3 Ibid. at 22-23.
The success of rehabilitation programs is impossible to evaluate because artificial and meaningless terms are used to measure success. For example, of the 10,081 vocational rehabilitation case closures, 4,500 or 45% "required no further action". One might logically assume that success in the vocational rehabilitation context means vocational goals are met: the worker secured a job independently. Clients seeking legal advice frequently "required no further action" because benefits were terminated before vocational rehabilitation started or soon after. 'Success' as measured by "required no further action" often simply means that the W.C.B. and vocational rehabilitation refuses further assistance to unemployed workers.

The Board's statistics show that only 4,874 or 43% of the 11,269 referrals to vocational rehabilitation were employed. Even supposing that some workers who "required no further action" found jobs, the statistics address quantity, ignoring the quality of the jobs. Type, suitability, or the duration of the employment is not a measure of success. How many of this 43% are working at jobs paying significantly less and/or with little to no chance for advancement compared to the pre-accident employment? A parking lot attendant at minimum wage is a poor replacement for a highly paid, pre-accident welding or construction job. Without better information and a reasonable definition of 'success', the Board's annual report is useless for determining the quality and thus, the acceptability, of vocational rehabilitation services.

The Annual Report boasts an 83.6% success rate, defined as "medically fit to return to work" upon completion of the "full-treatment program at Downsview". Success is neither full medical recovery or vocational integration. Considering that hearings held by appeal adjudicators increased by 25.5% and requests for files where an objection was raised increased 33% in 1985, that the office of the Workers' Compensation Appeals Tribunal (W.C.A.T.) states the hearings roster is so backlogged that hearings will not be scheduled for at least a year; and the existence of a six month client waiting list at the Office of the Workers' Advisor; the suggestion that greater than 80% of injured workers are "successfully rehabilitated" is incredible. These statistics on case closures and the increased appeals are very consistent with the contention of workers that files are closed prematurely because attention is directed at closing files instead of ensuring real and meaningful vocational/medical rehabilitation. The fact is that too many "successfully rehabilitated" workers are not rehabilitated at all: they are merely disentitled.

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Apparently, 'success' from the W.C.B.'s perspective means fiscal restraint through premature disentitlement.

The cost of rehabilitation service is significant. Ineffective treatment which fails to meet its objectives is worthless despite the apparent cost savings and the statistically impressive rate of file closures. The W.C.B. annually reports statistics which avoid all of the issues of quality and thus, the true value and the human costs can never be evaluated.

THE BOARD'S POSITION ON MEDICAL AND VOCATIONAL REHABILITATION

Appropriate medical rehabilitation is essential to the successful vocational rehabilitation of injured workers and both are central to worker compensation schemes. The importance of integrating medical rehabilitation and vocational rehabilitation is recognized in the Ontario philosophy:

"The rehabilitation process achieves its best results when medical, social, educational, and vocational measures are appropriately combined and co-ordinated.

It is the right of workers and surviving spouses to participate fully in planning their own rehabilitation".8 (emphasis added)

Despite this progressive statement of intent, the fact remains that there is little co-ordination or worker participation. Vocational counselling is rarely initiated early in rehabilitation and consequently those philosophical "best results" are rarely realized.

The following sequence of events characterizes the poor co-ordination of services. A roofer received total temporary benefits for ten months before being admitted to Downsview for three weeks. Upon his discharge, despite feeling that his prospects for office work were extremely limited by his education, he was referred for vocational rehabilitation and initiated a job search for modified work. At the six week medical follow-up, a Board doctor "deemed him fit to return to his regular job". Thus, before his first appointment for vocational rehabilitation, the file was closed, "no further action required". His pleas for retraining during his entire layoff were ignored. One year later, the injured worker is awaiting his appeal to the hearing officer, still looking for work, attending school and receiving welfare. He barely tolerates sitting at school all day and is unable to return to his former roofing job.

This case underscores several problems in the system. Firstly, vocational rehabilitation is requested too late and proceeds too slowly to help workers. The worker ceases to qualify, before help is given and regardless of ability or real potential for finding work. *Early* vocational rehabilitation must be available to be meaningful, not merely statistical. Secondly, poor communication among Board doctors and with rehabilitation services is glaringly obvious. Thirdly, the worker is the ultimate loser: no benefits, no vocational rehabilitation, no job and no dignity. The Board's philosophy for co-ordinated rehabilitation may be ideal, but the *reality for this man and too many others is abandonment and welfare.*

Injured workers are similarly prevented from planning and integrating their vocational rehabilitation with medical rehabilitation or anything else. For example, workers may not attend school part time while on temporary total benefits. The stated rationale is anyone well enough to attend school can work, therefore must initiate a job search. The worker is in the position of either looking for modified work, which probably does not exist, while still 'totally' disabled vis-à-vis the pre-accident employment or sitting at home doing nothing. The rigidity of the system squashes workers' initiatives. The Board is too preoccupied with defining pat formulae for controlling benefits to follow its stated philosophy on the workers' rights.

Quality of care and co-operative efforts between health care providers and the recipients of the care is essential. Without consumer accountability and co-operation, problems which arise cannot be resolved because the worker lacks all consumer choice and control. The injured worker always finishes last when the relationship is unsatisfactory.

Section 52 (1) of the W.C.B. *Workers' Compensation Act* provides that:

"*Every worker who is entitled to compensation under this Part or who would have been entitled had he been disabled beyond the day of the accident is entitled,*

(a) to such health care as may be necessary as a result of the injury".9

Section 52(2) of the Act defines health care to include "drugless practitioners" under the *Drugless Practitioners Act* R.S.O. 1980. This includes physical therapists and many other rehabilitation therapists in Ontario, but excludes occupational therapists and others. Although health care is legislatively provided for as of right, it is limited and discretionary to some extent.

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Section 54 of the *Workers’ Compensation Act* in regard to "Rehabilitation" states:

"To aid in getting injured workers back to work and to assist in lessening or removing any handicap resulting from their injuries, the Board *may* take such measures and make such expenditures as it *may* deem necessary or expedient..."¹⁰ (emphasis added)

Section 54 is not available to the worker as of right, rather is discretionary. Beyond these two sections, the Act is silent regarding any positive right to rehabilitation. There is no right to participate, to collectively decide on or individually choose practitioners, form or place of treatment, or duration of lay off. Save for the initial choice of treating physician under Section 52(1)(b), the worker has no alternative but to submit completely, or risk losing his/her benefits. Benefits are lost when the worker:

"fails to co-operate in or is unavailable for employment, medical or vocational rehabilitation which would, *in the Board’s opinion*, aid in getting the worker back to work."¹¹ (emphasis added)

The Board’s sweeping powers to determine treatment and terminate benefits compared to the total lack of legislative recognition for workers’ rights to participate in the rehabilitation process are particularly striking when contrasted with the Quebec legislation:

S. 146 "To ensure the worker’s right to rehabilitation, the Commission shall prepare and implement, *with the worker’s collaboration*, a personal rehabilitation program, which may include, according to the worker’s needs, a physical, social and professional rehabilitation program.

The program may be modified, *with the worker’s collaboration*, to take account of new circumstances."¹² (emphasis added)

Further contrast this to the medical world beyond the W.C.B. and Downsview, where pain is considered nature’s way of setting physical limits and health care is a consumer commodity thereby encouraging participation and free informed choice. When pain restricts their ability to perform "rehabilitation" programs, the absence of personal control or co-operative planning in their health care, especially when at Downsview, puts injured workers at the mercy of sometimes intolerant Board personnel. At Downsview, pain and participation spells disenitlement.

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¹¹ *Ibid.*, section 40(2)(b)(i); see also s. 45(5)(a), s. 75(4), s. 86h(7).

¹² *Workers’ Compensation Act* R.S.Q. 1985, "Right to Rehabilitation", chapter IV, s. 146.
The philosophy of "participation", unsupported and effectively negated by legislation, cannot survive reality and its consequence is underscored by the interpretation placed on the worker's responses to pain. Any perceived failure of the worker to 'co-operate' with the rehabilitation program, particularly at Downsview, causes the worker to be labelled as non-complying, lazy, having inadequate motivation, or a malingering. On the other hand, workers who co-operate despite increasing pain find themselves accused of laziness, exaggerating their subjective complaints of pain, suffering from "psychogenic", "supra-tentorial", "it is all in your head" pain, or malingering. Co-operation works against the injured worker, apparently proof positive that "organic or real" pain never existed. Similarly, injured workers whose previous complaints of pain are ignored, find emphasizing the presence of pain in an effort to convince the unsympathetic Board employee of its existence, also militates against the worker, earning the same labels.

Many workers may reasonably decide that co-operation with Board employees, who misconstrue their every effort, will not be in their best interest. The strong sense that rehabilitation is secondary to the "closing of files" and the "settling of benefits claims" flies in the face of any philosophy of "co-ordination of services", "full participation" and "best results".

An anti-worker animus, rooted in legislative silence regarding the right of workers to participate in their rehabilitative management and supported by sweeping powers given to the W.C.B. taints every aspect of health care administered by the Board.

BACK PAIN: A MEDICAL CONUNDRUM

Back injuries are problematic both for injured workers and for the W.C.B. because the workers' pain almost exclusively accounts for limited function and inability to return to work. However, it is normal in the practice of medicine to deal with people with discomfort or pain which interferes with their normal daily functioning, and it is the exceptional cases where the primary complaints of those seeking rehabilitation therapy exclude pain. The pain may or may not have caused a myriad of secondary problems. Thus, the fact that some injured workers state pain causes functional limitations should not be considered unusual.

Most causes of pain are easily identified, diagnosed, and the root cause treated. A sprained ankle or other peripheral joint is readily diagnosed and conservatively treated by a cast, bandage or the use of crutches. Even when the root cause is not determined, the body is a wonderful creation effecting its own cures over time in a majority of cases. Over 80% of back-
ache spontaneously resolves within weeks,\textsuperscript{13} and apparently regardless of which, if any, medical treatment(s) are prescribed or followed.\textsuperscript{14} The medical profession is divided on the issue of treatment of backache. "The cause of nearly all backache is indeterminate."\textsuperscript{15} This fact, alone, underlies the many reasons why backache is a medical conundrum.

Firstly, the anatomy of the back makes accurate diagnosis difficult. The joints of the spine are small, close together and underneath muscle. The movement of each joint of the spine is miniscule compared to peripheral joints like the knee, and spinal motion results from many joints moving in symphony. Neither adjacent spinal joints nor the component parts of a single spinal segment rest on a single plane and most of the structures which give rise to pain are soft tissue, not bone. This means that x-rays have limited value and palpation techniques used to examine peripheral joints are rarely used when assessing spinal problems or, if attempted, the examiner cannot find anything meaningful due to lack of special expertise and touch sensitivity. The spine is rarely diagnosed accurately because of anatomical difficulties and the relatively high natural "cure" rate has removed the incentive to improve technical and diagnostic testing to make accurate diagnosis possible.

Secondly, the practice of medicine is a mixture of the art and the science of healing. The emphasis given to science or art is a matter of professional choice, and depends on age, experience and/or educational background. Within this climate of varying "scientific" approaches, most opinions on optimal back treatment are unsupported by scientific logic. While the assumption that the treatment given during the period of acute backache 'results in' the resolution of symptoms is unsupported by statistical studies,\textsuperscript{16} the pure scientist/researcher view, that the absence of statistical variations in recovery rate related to treatment proves that no treatment is effective, is also flawed. Backache sufferers have found through personal experience that all treatment is not equally effective. Sometimes a given treatment has a positive effect or no effect. Some have discovered that the treatment is unrelated to their rate of recovery, but treatment alleviates the acute pain.

The apparent inconsistencies between the scientific conclusions, the observations of healers and individual patients are not irreconcilable. Whereas personal and medical experiences have not been scientifically


\textsuperscript{14} N.M. Hadler, "Regional Back Pain" (1986) 315 \textit{The New England Journal of Medicine} at 1090-1091.

\textsuperscript{15} \textit{Ibid}.

rationalized, the research rests on false premises. "Backache", "low back pain", "mechanical back pain", "back strain" are not diagnoses, as many doctor/researchers would have us believe. They are merely descriptions of one symptom and are neither useful nor accurate because the sources of backache are multifarious. Medical knowledge is not advanced when a patient says: "I have a sore back" and the doctor sagely diagnoses the problem as "backache".

Swelling, bruising, tearing, or breaking in many structures, such as ligaments, internal joint structures, muscles, tendons, nerves, or discs may cause pain: all backache is not physiologically or anatomically homogeneous. "Backache" is no more an acceptable medical diagnosis than "leg ache" or "arm ache". Nor would one expect statistical variance in recovery if research was based on randomly applied treatment to leg pain, without regard to etiology. Where the method is faulty and illogical, the results are not better, and normally the medical community would rail at the inadequacy of results founded on such a poorly defined, heterogeneous research group. The failure of scientific logic and knowledge have resulted in "backache" being approached in this unacceptable manner. Thus, simply stated, the reason a given treatment is apparently effective in reducing the duration of backache is that by trial and error, and despite the failure of the medical profession to make an adequate diagnosis, the patient finds the best cure. Conversely, medical cures are not statistically effective because they are randomly applied with no rational basis underlying the selection of treatment. One might most logically infer that back injuries resolve despite medical intervention, not because of it.

Thirdly, the natural history of back disease gives rise to additional management hurdles. Backache is characterized by episodic pain with interceding remissions. The onset of pain can stem from seemingly insignificant events, which vary vastly between patients and even between episodes in the same person. There is no medical "cure", only symptom alleviation. Backache is frustrating and boring to treat in an era of wonder drugs, microscopic surgery, transplants and high-tech, computerized equipment. The commonly heard phrase "there are no objective findings" which means "I found nothing, ergo there is nothing" underscores the myopia regarding the limitations of medical knowledge. The medical profession is patently fooled by its own public image of omnipotent healer.

Pain is a subjective symptom. Pain is not objectively or accurately quantifiable; it is not observable to the naked eye. Pain cannot be determined by x-ray or any other test. The root cause of pain cannot necessarily be determined during surgery. The signs associated with pain or the limited use of the painful part, however, can be seen or measured. Local swelling or muscle spasm may result from using an injured part or, conversely cause pain and disuse. Stiffness or weakness may result from favouring a painful part or from the physiological effects of swelling
and muscle spasm. Once the pain cycle is well established, the proportionality between pain, weakness, stiffness, and spasm is even more tenuous. While inadequate assessment techniques and anatomical structure of the spine make signs difficult to find, the "chicken or egg" nature of pain and associated observable signs underscores their inadequacy as conclusive indicators of the presence or absence, and the extent of pain.

Similarly, positive x-ray findings are rarely present at the outset. When abnormal x-ray findings exist, there is no correlation between the degree of the abnormality and the extent of the pain experienced. Although, it is often stated that this is due to non-organic factors of pain appreciation, that is, emotional factors, it can be reasonably argued that acute or recent pain is never due to the x-ray findings. The x-rays do not change when the pain occurs or resolves. The same may be said for chronic pain: it varies dramatically hourly and daily, depending on activity level and position; x-rays do not. Every health care practitioner has seen x-rays showing extensive arthritic damage in a person who is symptom-free and conversely, a person bed-ridden with back pain whose x-rays are "normal". X-rays, likewise myelograms and C.A.T. scans, are structure specific tests with limitations. Thus, the absence of so-called objective findings should never be conclusive in ruling out all organic bases for pain.

A leading American authority underscores the obsession which the medical profession and worker compensation schemes have in accepting pain as "real" unless it can be labelled, visualized or otherwise substantiated.

"To this day, workers who have backaches while at work are given a diagnosis of "ruptured disk", they will be compensated in nearly all jurisdictions, regardless of the presence or absence of a discrete cause of their symptoms. A well placed surgical scar serves to squelch arguments to the contrary far more reliably than the surgical procedures serve to improve symptoms".17

The difficulties in quantifying and diagnosing back pain, and pain generally, may account for the widely held medical and compensation scheme myth that undiagnosed pain is not a functional disability equivalent to an amputation or operation or any other visible disorder. Recognizing the existence of the myth explains to a large extent the W.C.B.'s hard-line policies and management for injured workers complaining of unresolved back pain.

A fourth problem with the medical management of backache is that the back, unlike any other joint in the body, is constantly under some degree of loading stress during sitting, standing, and even some lying positions. A painful peripheral joint can be compensated for by favouring the oppo-

17 Hadler, supra, note 14.
site limb, using a cane, crutch, or wheelchair to reduce the stress on the joint. The extent of an individual's ability to compensate is best observed in premier competitive athletes. Many professional and premier amateur athletes ably develop and use one leg or arm almost to the exclusion of the other to compensate for pain. They remain competitive by modifying their technique and by effectively reducing stress on the painful joint. In contrast, when an athlete sustains a back injury, a layoff is frequently required and a shortened career expectancy almost invariably results. The reason is that adequate compensations to reduce the strain on the back do not exist and at some point the pain is intolerable regardless of the degree of motivation to be productive.

Many injured workers are in the same difficult situation. Most unskilled jobs cannot lend themselves to the special needs of the injured worker and at some point "light" work is not light enough. The position alone excessively compromises the integrity of the spinal structures so that pain cannot be controlled. Further, light work is often defined as limited lifting and frequent position changes. These restrictions are meaningless to most employers and do not functionally define or adequately limit the majority of stresses to the spine. Housewives commonly specify vacuuming is impossible with backache, and yet injured workers are repeatedly sent to sweeping and general clean-up jobs as suitable light work.

Anatomically complex spinal structures, difficulties in assessing and diagnosing the root causes of pain, and the difficulty in modifying work and homelife to reduce the strains to the back challenge medical and rehabilitation specialists. The challenges are largely unmet and explanations of psychological deficiencies in patients are an inadequate resort.

DOWNSVIEW: A REHABILITATION CENTER?

Access to Downsview Rehabilitation Center for the purposes of this paper was denied to the author. The request was too "politically sensitive" and had to be taken to "the top"; recent negative publicity had resulted in low staff morale which would not be assisted by further inquiries; the Board was making its own internal evaluations. Public accountability and reasonable access take a back seat to the ebb and flow of staff morale.

As a result, recent first hand observations and a wider cross-section of opinion were precluded. None of the practitioners surveyed were currently employed at Downsview. The workers surveyed were clients of legal clinics. The opinions expressed were widely shared and were supported by specific examples. Downsview received no accolades. The shared experiences demonstrate flaws in the system that are so basic and deeply rooted that reporting a few positive experiences could not mitigate the overwhelmingly unhealthy, non-rehabilitative picture of Downsview which is presented.
The first area of concern expressed by workers and practitioners was that Downsview functions primarily as an assessment as opposed to a rehabilitation or treatment center. W.C.B.'s internal investigation has confirmed this. Occupational therapy staff attributed the lack of treatment, at least to some degree, on the high caseload requirements. Approximately fifteen new assessments per week made individual attention beyond the assessment improbable.

Students suggested that the will to "treat" was absent in staff members. Therapists observed patients from a glassed-in office. This distancing creates many negative consequences. Primarily, workers receive less "treatment": treatment being defined as closely monitored therapy management which is individual to the patient. In addition, the therapist-patient relationship is severely compromised.

Development of a close trusting relationship is particularly important because workers are aware how much their future depends on the outcome of the assessment. Workers know that therapists report to the Board doctors, who ultimately determine benefits. Patients who do not trust the motives of the health care provider are less likely to co-operate with treatment. Distancing further interferes with treatment. Minimally, workers must trust and believe that the actions of the health care providers are motivated primarily if not completely by professional concerns for the best interests of the worker. Workers do not believe therapists' motives are totally directed to their best interests.

One occupational therapist told a client of Parkdale Community Legal Services that he was "faking it" because he was "not co-operating". From his perspective, he was participating in his treatment by stating he was limited in carrying heavier weights by his increasing back pain. The Board doctor agreed, commenting on the discharge report that objective signs of pain and his back condition had deteriorated during his admission to Downsview. This worker was in no doubt of the role played by the therapist. The worker's complaints were ignored, treatment goals were not advanced, his best interest were not paramount. The deleterious effect that participation in benefit control has on treatment objectivity is apparent:

"(A)t the W.C.B. you are expected not to play the role of healthcare giver as much as enforcer of Board policy. The role of the O.T. is to monitor the patient; checking for inconsistencies".18

In addition, the assessment fails to provide long-term, on-the-job benefit to the worker. The injured workers are only accidentally assisted by the

18 Anonymous, "The Socialization and Professionalization of Occupational Therapy Students" (paper by an occupational therapy student who did an internship at Downsview Rehabilitation Centre) (1986) [unpublished].
assessment. Workers returning to modified work are given specific prescriptions of limitations: no lifting more than 'x' kilograms, not above the waist or in certain positions, no repeated bending, no prolonged stooping or sitting, or frequent position changes. The prescriptions do not accurately reflect the extent of the disability. It is no more than a prescription to terminate total temporary benefits and the first step to complete disentitlement.

A day at Downsview is broken into hourly intervals, thus work limitations are determined by what the worker can do in 45 minutes, not in eight hours. This introduces significant error into the prescriptions for work. It is well understood that the strains on the spine are cumulative over time. A person may be able to do eight hours of lifting in a day, but not for eight consecutive hours or for five consecutive days or weeks. The defect in this approach is evident: A foundry worker coped with his injured back until a second, minor incident severely disabled him. After his first injury and on his doctor's advice, he only lost two work days. For five months he went to work four hours early so that he could lie down in the middle of his shift. He managed because he worked at night and there was no punch clock or supervisors. He was single, enabling him to rest in bed all day. Predictably, his pain gradually worsened and he re-injured his back. Ironically, following the second injury, the doctor at Downsview told him his only problem was that he lacked the will to work. The Board doctor thus legitimated terminating benefits, ignoring the worker's past work history and stated inability to work. The inadequacy of an assessment which failed to reflect the true demands of the worker's job was overlooked.

The worker's limitations are not translated into practical terms, thus the injured worker cannot always apply them on the job. The worker does not practice coping with physical restrictions imaginatively or in situations which resemble the workplace, where the physical demands are often unpredictable. The worker practices lifting compact weights from place A to B: no awkward, large boxes in narrow passages, around corners, over obstacles, under low overhangs, up or down ladders, and no pressure to hurry. Rehabilitation is learning methods of coping with the specific physical and environmental demands of a personal job situation, to make the environment work for, instead of against the worker. This must go hand in hand with equipment modifications. To be "fit to return to roofing with no lifting more than 15 kilograms above waist" is all very well, but how do the shingles get from the truck to the roof? Workers need the means to resolve problems, not artificial and meaningless limitations which only serve to make the worker less attractive in a competitive job market.
A second recurring theme among those surveyed was the "negative atmosphere". Anti-worker animus was openly expressed during the employee orientation to Downsview. One person was told that the greatest problem facing the therapist was the patient's lack of motivation: Italian women were the worst complainers, they did not want to work outside the home and do their housework. Besides being racist and sexist, this comment reflects a poor understanding of reality. Both men and women have physical demands on the job, as well as at home. Injured workers with pain must make compromises at home and at work. Surely, workers are not expected to forfeit all quality of life outside of work.

The philosophy of 'secondary gain' was explained to students as being the reason workers refuse to work. Apparently, "workers are too comfortable on benefits", after all, "Downsview was filled when INCO was on strike". If there is any statistical truth to this, the Board has not made it public. Certainly, no dramatic increase in admissions to Downsview is shown until 1985.\(^{19}\)

Students were impressed with the concept that the injured workers were considered to be malingering and cheating the system until "proven innocent". A Board doctor taught assessment tests to identify malingerers. Students were given literature explaining the highly emotional nature of pain. One such article explains:

"[A]s the duration of the pain and suffering lengthens, the role of psychogenic magnification grows...Patients who remain disabled as a result of their back pain are usually suffering the damaging effects of chronic pain on their emotional response...absence from work for as little as 10 weeks because of pain affects the patient's motivation and ability to return to regular employment."\(^{20}\)

Students learned a new vocabulary. Labels such as "supra-tentorial pain" (all in the head) describe pain without objective signs. This term is not unique to Downsview, but a second is. Co-existing with the presumption that workers are malingering is the presumption that they exaggerate their symptoms. Injured workers are said to be "contaminated" by veteran injured workers. Supposedly, injured workers start to exaggerate their symptoms at some point after their arrival at Downsview because they have been counselled to do so by other injured workers. Such a conspiracy amongst an ever-changing worker population is unlikely but the concept is conveniently available to explain any treatment failures, displacing any blame from the practitioner, the treatment approach, or nature onto the injured workers.

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\(^{19}\) Annual Report 1985, supra, note 1 at 14.

\(^{20}\) Back Again, supra, note 16.
The deleterious effect on health care that presumptions of "contamination" carry was real to a client of the Industrial Accident Victims Group of Ontario. During his admission to Downsview for rehabilitation of his back, he heard a crack accompanied by shoulder pain while exercising on a machine. He consulted the Board doctor who clearly did not believe him, did not examine his shoulder and advised him to carry on and ignore it. The worker trusted in the doctor's instructions to his continuing detriment. He is understandably bitter today. His shoulder injury was never recognized as compensable. He now has unresolved back and shoulder pain. Despite twelve years of loyal service, his accident employer refused to rehire him, ostensibly because he could no longer perform his old job. His benefits have been terminated.

Collectively, the comments show the extent to which many staff members are pre-occupied with non-organic causes of pain and the presumption that workers' disabilities are fabricated or exaggerated. This negative mindset could never be intended to assist the injured worker to resolve his/her problems with pain, whether organic or psychogenic. The rehabilitation staff are ever mindful of and actively practicing an adjudicative role at the expense of their rehabilitative role. This adjudicative role may superficially advantage the Board's coffers, but lacks any curative benefits for injured workers and does not meet the philosophical intent of the compensation system.

Finally, one must note that the interpretation placed on pain is clearly inconsistent with the pronouncement of the Workers' Compensation Appeals Tribunal (W.C.A.T.) A number of decisions have addressed the issue of entitlement for chronic pain. The W.C.A.T. equated honesty and credibility with "real" pain. "Real" pain has been defined as pain that is real to the worker, is disabling and resulted from the work accident. The origin of the pain, whether from psychogenic or undetected organic causes or a combination of the two, has been unimportant to entitlement. In one case, the psychogenic pain was found to be "real" and thus compensable. In addition, the tribunal has made the following observation:

"Medical literature attests to the acceptance by the medical profession of the fact that it is not uncommon for there to exist pain or muscle spasm that is real and disabling and for which no organic cause can be found. Often it is seen to be rooted in a post-traumatic psychological reaction that produces physiological effects, but there is also recognition that the origins of pain are not fully understood and that there is real pain that
Finally, it is important to note that the anti-worker animus at Downsview may simply be an exaggerated, socialized and bureaucrati-
ized form of a generally accepted view of workers. One of the rehabili-
tation students that attended Downsview for training surveyed thirty classmates regarding their attitudes toward health care and the W.C.B.
The same anti-worker prejudices were found, if less well articulated. Almost half of the students felt that medicare created abuse of the health care system. Two-thirds were of the opinion that less than 60% of W.C.B. benefits were justified and only one thought that 80-100% were justified. Students were predominantly middle class, white, English-speaking and female. This accurately describes many if not most health care providers, except doctors who differ to the extent of being predominantly male.

Downsview is an institution of medical practice reflecting the fiscal concerns and policies of the W.C.B. Downsview is not a rehabilitation center. It is a benefit control center. The rehabilitation of injured workers is interfered with by the adjudicative role played by health care provid-
ers at Downsview. Rehabilitative and assessment goals are defeated by the suspicions and anti-worker animus that prevails at the center. It is too difficult to overcome those basic prejudices, exaggerated and rein-
forced at Downsview, to form healthy worker/practitioner communica-
tion. Collecting workers together in one institution encourages the wholesale abuse of injured workers under the guise of specialized medi-
cal programs and "rehabilitation".

CONCLUSIONS

It is ironic that the W.C.B., historically intended to protect injured workers from the avarice of employers and to avoid the expense of lengthy, adversarial legal proceedings now sits with the employer as a party with competing financial interests adverse to the injured worker. Many injured workers require protection from their protector. Financial restraint policies through premature benefit termination have taken precedence over the real and meaningful rehabilitation of injured workers. Equally lengthy and often adversarial bureaucratic proceedings have replaced the traditional legal proceedings. However, there is one significant difference: one of the adversaries is the decision-maker.

23 W.C.A.T. Decision No. 11 at 2.

24 "The Socialization and Professionalization of Occupational Therapy Students", supra, note 18.
The worker shares the health burden with the general population, when medical science reaches its limit. However, many injured workers have the additional problem of earning a living by the strength of their backs and the added insult of having to deal with Downsview. When the W.C.B.'s benefit control/medical center is finished the injured worker is deserted, alone with the pain and the poverty. For the worker with back pain, discharged from Downsview and disentitled from benefits, compensation or further vocational or medical rehabilitation, the indignity is complete. The example of workers with back pain was used in this paper to provide a specific focus for this examination of Downsview. But the plight of workers with back pain is shared by many other workers with other complaints, and merely serves to illustrate problems endemic to the entire workers compensation scheme. The injured worker bears an unnecessarily high social burden.

The first problem that faces the critic of the W.C.B. is that thorough evaluation of the scheme is almost impossible. Where the statistics show very well the numbers of workers participating in a program, the efficiency and benefit of the program to the worker and Ontario is indeterminate. It is short sighted and misguided in the extreme to pretend that disentitlement leading to unemployment, welfare or personal dependence is being either "financially independent" or "successfully rehabilitated", or is socially beneficial. The statistics illustrate the bottom line thinking associated more with uncaring businessmen than a social program where human and social benefits are intended to be the mandate. The statistics are available, however unhelpful, but the programs and the 'operating' policies of the W.C.B., such as those at Downsview, are secret and inaccessible to the critical eye. It may well be that it is the very uselessness of the statistics that renders them suitable for the public eye.

Injured workers have been demanding for years that Board doctors are unnecessary and should be removed; that Downsview is a benefit control mechanism, doing little to rehabilitate and should be dissolved; and that the injured worker must have the legislatively recognized right to return to meaningful employment following a work-related injury. Injured workers have first-hand experience of the symptoms of the bureaucratic cancer, the W.C.B.'s policies. Downsview, Board doctors, and the "deemed fit to work" criteria are merely the symptoms, the institutions reflecting a philosophical approach based on unfounded, possibly class-related suspicions about workers. The suspicions are unmitigated by the established relationship that the worker's own physician and therapist develop. This philosophy is one which seeks to limit the W.C.B.'s scope and responsibility by turning a blind eye to the work-related disabilities and inability to work of too many workers.

The dissolution of Downsview, Board doctors, and false criteria concerning ability to be employed is a starting point in improving the fairness of the scheme; however, it is predicted that they will be replaced by other
equally damaging institutions and policies. The resolution of the prob-
lem will not come without legislative reform which spells out the philo-
sophical basis of the scheme and the rights of injured workers. And it is
the only means of approaching some form of substantial political and
public accountability for the W.C.B.'s policies and practices.

The W.C.B. is a bureaucracy out of control. The Board avoids both effec-
tive public scrutiny and political debate over many of its operations and
policies. Two concepts must be certain: "policy medicine", that is medi-
cine practiced for the purpose of fiscal restraint through benefit control,
will never be appropriate. Secondly, Board doctors and medical reha-
bilitation therapists must relinquish their role in benefit control. The
W.C.B. must look for alternate means of scrutinizing the medical and
rehabilitation professions, whom W.C.B. apparently believes are inca-
pable of objectively and correctly determining the health and abilities
of their patients, the injured workers of Ontario.