Managing Claims or Caring for Claimants:
Effects of the Compensation Process on the Health of Injured Workers

Katherine Lippel,
Marie-Claire Lefebvre,
Chantal Schmidt and
Joseph Caron

UQÀM Service aux collectivités
Université du Québec à Montréal
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Katherine Lippel¹, Marie-Claire Lefebvre², Chantal Schmidt² and Joseph Caron²

Research Report

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Managing Claims or Caring for Claimants: Effects of the Compensation Process on the Health of Injured Workers

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1
Introduction

For many years now, the Assemblée des travailleuses et travailleurs accidentés de Québec (ATTAQ), an umbrella group bringing together several injured workers’ advocacy groups across the province, and the Union des travailleuses et travailleurs accidentés de Montréal (UTTAM) have worked to defend the rights of injured workers. Our research team, specialized in occupational health and safety law, and these organizations, share a long history of collaboration. In 2002, the research team, in partnership with these two associations, undertook a research project that went beyond the purely legal framework to examine the impact, both positive and negative, of the compensation process on the health of claimants. This study was made possible by a grant from the Social Science and Humanities Research Council of Canada.

Because of our past experience with injured workers seeking compensation we were aware of potential negative health effects of the claims process itself and those who represent victims of employment injuries know they are often angry, sometimes depressed and, in certain cases, suicidal, yet no Québec study had addressed the health effects of the compensation process. This study attempts to pinpoint both the aspects of the process that have a protective effect on the health of the claimant and those that aggravate the impact of the injury or illness.

Methodology

In this study we drew upon a variety of sources of information. In January 2002, we met with representatives and members of injured workers associations affiliated with ATTAQ in the context of a day-long collective interview that allowed us to together define the priority questions and to share information regarding the way the study would unfold. Subsequently, we conducted individual interviews with 85 workers in 6 regions of Québec: Greater Montréal, Lanaudière, Abitibi-Témiscamingue, the Laurentians, the Montérégie and the Eastern Townships.

Who participated in the collective interviews?

Besides individual interviews with workers, we conducted six collective interviews with people who represent injured workers in Québec (lawyers with expertise in the area and people working with the advocacy groups that participated in this project), in Ontario and British Columbia (workers’ representatives; some lawyers, some not). These interviews, conducted in 2003 and 2004, had the following objectives: 1) to identify the particular problems faced by workers in precarious employment; 2) to identify the special difficulties experienced by people suffering from injury or illness resulting from exposure to neurotoxic substances; 3) to identify the perspective of staff from the injured workers’ associations; 4) to identify the perspective of lawyers who represent injured workers. Interviews conducted outside of Québec were intended to create a basis for comparison with other Canadian provinces to identify the beneficial and detrimental aspects of our respective compensation systems. Special attention was paid to surveillance of workers by private detectives at the behest of employers or the compensation board (in Québec, the Commission de la santé et de la sécurité du travail or CSST) and its effects on the health of claimants.
Who participated in the individual interviews?

- 42% of participants in the individual interviews were recruited by our partners (member associations of ATTAQ, UTTAM, CTTEA, CATTAM, ATTAT and ATTAM, see listing at the end of this report);
- 41% of the participants contacted the research team after having seen an ad (an advertisement in a newspaper, posters in medical or physiotherapy clinics or offices of lawyers specialized in workers’ compensation law) or were referred to us by other research teams, by injured workers already participating or by members of the research team;
- 17% had been interviewed in the context of a related project that focused specifically on the appeals process.

The people interviewed came from different employment sectors: the healthcare sector (19%), particularly public healthcare (17%), was the most highly represented sector; then followed the primary resources sector (forestry and mining) (11%), transport (road, railway, school transport, etc.) and construction (*ex aequo* at 7%)

In our sample, manual labour was primarily represented by men. In the area of white-collar employment, women had a somewhat higher level of representation.

Women made up 48% of the interviewees; they were on average more highly educated than the men and more often from Montréal. Overall 49% of the interviewees were unionized at the time of their injury or illness. This level of unionization is above the national average.

78% of the interviewees used French as their first language, compared to 7% English and 15% other languages. The interviews were conducted in French or English based on the choice of the injured worker.

82% had been injured in an industrial accident, while 18% suffered from an occupational disease.

We wanted to be certain that we had an overview that took into consideration the largest possible range of experience. As is indicated in Table 1, 79% of the claims filed by the interviewees were accepted in whole or in part by the CSST, with women’s claims rejected more often than those of men. Some workers received immediate compensation; even so, some had to subsequently defend themselves in the context of an appeal launched by the employer. Others had to challenge an initial refusal in order to have their injury or illness recognized. Some cases were only partially accepted; the occupational basis of the injury or illness was recognized, without sufficient acknowledgement of the consequences of the injury or illness.

<table>
<thead>
<tr>
<th>Sex of claimant</th>
<th>Accepted</th>
<th>Partially Accepted</th>
<th>Refused</th>
<th>Total</th>
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<tbody>
<tr>
<td>F</td>
<td>13</td>
<td>15</td>
<td>13</td>
<td>41</td>
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<tr>
<td>M</td>
<td>13</td>
<td>26</td>
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<tr>
<td>Total</td>
<td>26</td>
<td>41</td>
<td>18</td>
<td>85</td>
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<table>
<thead>
<tr>
<th>Sex of claimant</th>
<th>Percentage</th>
<th>Partially Accepted</th>
<th>Refused</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>F</td>
<td>32%</td>
<td>37%</td>
<td>32%</td>
<td>100%</td>
</tr>
<tr>
<td>M</td>
<td>30%</td>
<td>59%</td>
<td>11%</td>
<td>100%</td>
</tr>
<tr>
<td>Total</td>
<td>31%</td>
<td>48%</td>
<td>21%</td>
<td>100%</td>
</tr>
</tbody>
</table>
At the time of interviews, some files had been active for only a few months while others had been active for many years, and most were still active. Some workers had suffered their original employment injury when the *Workers’ Compensation Act*, applicable until 1985, was still in effect.

The majority of the interviewees provided us with information regarding their personal and family income, both at the time of injury and at the time of the interview. This information was not verified, but there is no reason to believe that there were significant failures of memory or errors in approximation that would tend to affect categories of people differently in a way that would prejudice the results. We asked the injured workers to situate their family revenue within an income bracket (less than 20 thousand dollars, 20 to 30 thousand, 30 to 40 thousand and more than 50 thousand). A significant number of people provided exact figures; in other cases, we utilized the average for statistical purposes. The results are reported in 2003 dollars. We used the index adjustment rate provided by Statistics Canada and the consumer price index in our calculations.

These figures served to situate the income levels of our participants but can not be used to draw conclusions regarding the economic impact of an injury on injured workers in general. It should also be noted that this data was gathered prior to fiscal legislative changes brought in by the Québec government in 2004, that have reduced the net income of claimants. As such, we can safely assume that the current situation is, if anything, less favourable than the situation depicted in this report.

The accident (or occupational disease) appears to have had a significant negative impact on the income of the people we met with. In absolute terms, almost all of the injured workers indicated a decline in their income between the time of the accident and that of the interview, with 60% of them sliding into a lower income bracket. Adjusting for inflation, income at the time of the interview represented on average 68% of earned income at the time of injury. There was, in this regard, a marked difference between men and women; men reported receiving 72.6% of their previous income compared to 64.2% for women. Family income was, in relative terms, less affected. It stood at 77.3% of previous income, and in this case there wasn’t a significant difference between men (78.7%) and women (76.2%).

The tables on the next page illustrate this phenomenon. Table 2 reflects the situation of all respondents. Tables 3 and 4 reflect the respective circumstances of men and women. Table 5 presents the family income of all respondents. One can see the bar measuring the number of workers within the income category at the time of interview gets smaller in the higher income brackets, while it noticeably increases in the lower income brackets. This demonstrates the relative impoverishment of injured workers we met with. The income of injured women, which stood at approximately 80% of that of men at the time of the injury (approximately $32,900.00 vs. $41,200.00), fell to an average of 74% of that of men (approximately $20,600.00 vs. $27,800.00) at the time of the interview.

### How did we proceed?

The interviews started with general questions regarding the experience of injured workers and the consequences of both the injury and the claims process on their health. We also asked them for their suggestions regarding ways to improve the compensation process.

Questions were open ended and allowed the interviewees to identify and describe in their own words what they felt to be the important issues, as well as their feelings and perceptions about the therapeutic and/or anti-therapeutic aspects of the overall experience.
The interviews, which lasted between 1 and a half and 3 hours, were recorded and 82 of them were transcribed in extenso. A resume of each interview was also prepared. A careful reading and analysis of the transcripts facilitated the identification of the principle points made by participants. Coding and re-coding of the transcripts was conducted using N6 NVivo software and following the methods of grounded theory (Glaser and Strauss, 1967).

Information drawn from the collective interviews was compiled both to confirm the portraits gleaned from the individual interviews but also to draw out the differences and complimentary details furnished by the worker representatives, who perceived some issues from a different perspective.

**Overview of the results**

In the following pages, we will examine various factors that have an effect, be it positive or negative, on the health of the workers’ compensation claimant, including various steps in the process, as well as various social actors in the system. We will start by providing a summary of the repercussions of the process and then will identify the impact of various steps and actors in the process.

One of the objectives of our study was to give a voice to the people who are living with the experience of a work injury and, we were particularly interested in their experience of their compensation claim made under the Act Respecting Industrial Accidents and Occupational Diseases, the act governing workers’ compensation in Quebec. The interviews reflect a broad spectrum of reactions, running the gambit from extreme anger to relative satisfaction. In most of the testimony, we find workers expressing a continued hope of regaining the equilibrium they lost at the point that their life was disrupted by an industrial accident or occupational disease.

Many of the people with whom we met were suffering not only as a result of chronic pain, but also on a psychological level. It was often difficult, sometimes impossible, to distinguish

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1 84 interviews concerning 85 personal histories resulted in 82 transcribed interviews, 78 of which were coded and analyzed. In the case of certain themes, we took into consideration the observations of people whose interviews were not transcribed or coded either due to data saturation or a refusal to be recorded.
the consequences of the injury from those of the process. While a few had suffered only minor injuries, many had been seriously injured. The nature of injuries varied from one person to the next: various musculoskeletal disorders principally affecting the back and upper limbs, fractures, sprains, cuts, third degree burns to the entire body, diseases caused by exposure to various toxic substances (lead, carbon monoxide, beryllium, volatile chemical products), torn meniscus and other knee injuries, often resulting from a fall, traumatic brain injury and various mental health problems attributable to violent physical aggression or psychological harassment. Some people developed secondary injuries during the course of and at times as a result of the process. In some cases this led to new compensation claims, while in others it didn’t.

After clarifying the nature of the workers’ compensation system applicable to the workers involved in our study, we will present an overview of the health consequences of the process as experienced and described by the people we interviewed, after which we will address the various factors that positively or negatively affect the health of claimants. We will also examine several situations marked by distinctions linked to the gender of claimants, regional specificities or the non-standard or precarious nature of their work.

We conclude with recommendations designed to optimize the positive aspects of the system and reduce the negative ones.
Les recours

en cas d'accident du travail

La réadaptation

Le droit au retour au travail

Votre protection

l'indemnisation
The Act Respecting Industrial Accidents and Occupational Diseases (AIAOD) establishes the rights and responsibilities of workers and employers should a worker be involved in an industrial accident, develop an occupational disease or suffer a recurrence of health problems related to an earlier accident or disease (relapse, recurrence or aggravation of the initial injury). The Act came into effect in 1985, but the Québec workers' compensation system has existed since the early twentieth century.

As in other North American jurisdictions, Québec society seems to have collectively forgotten that were it not for workers' compensation legislation that introduced a “no-fault” system, industrial accidents and occupational diseases would have been the source of numerous civil law suits against employers. A no-fault system does not imply that employer or worker behaviour is without fault. Accidents are often chance events: a false step, a mistake on the part of a worker or a colleague, etc. But there are also cases in which working conditions or work organization create circumstances that lead to industrial accidents or expose the workers to conditions that provide fertile ground for the development of occupational diseases.

As in all countries with a workers' compensation system, employers, through their premiums, provide 100% of the financing for this CSST-managed program. They also receive protection against any and all civil proceedings brought not only by their own employees but also, with few exceptions, by any worker whose employer is covered under the Act. Contrary to the situation that prevails in France, where employers are liable for their “faute inexcusable” or inexcusable fault, in Québec, the protection from lawsuits that is extended to employers precludes civil liability even in cases of gross negligence. As a result, employer behaviour is rarely the subject of discussion in the context of the AIAOD.

Nonetheless, many of the workers we met with had suffered industrial accidents or occupational diseases as a result of employer negligence (see sidebar on the following page).

In recent years, the CSST has relied on experience rating, a system that personalizes the assessments of each employer according to its compensation record, purportedly to encourage employers to take steps to prevent accidents and disability. However, many workers told us that this incentive system has instead led employers to challenge workers' claims or to pressure workers to abstain from filing claims. An employee of a subcontractor in an outlying region told us that his employer forbids CSST claims and tells workers that a clause of his subcontracting agreement prohibits CSST claims. Regardless of the legitimacy of the employer's position, the worker and his colleagues were convinced that they could lose their jobs and that the employer could lose his contracts if claims are filed with the CSST.

Workers and their representatives inform us that since the advent of the “mutuelles de prévention,” small businesses are sometimes obliged to contest a worker's claim, even when

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2 The Québec workers' compensation system

3 The mutuelle de prévention is the term used to designate the «insurance product» offered to small and medium sized employers in Quebec who want to benefit from experience rating in order to reduce their compensation costs. They were introduced in 1997. Firms specialized in disability management (and to some extent OHS prevention) offer their services to groups of small employers who then share their «experience». An accident in one business will affect that assessment rate of all members. See http://www.csst.qc.ca/portail/fr/employeurs/informations_supplementaires/mutuelles/mutuelles_prevention_1.htm, consulted on March 3rd, 2007.
they believe it to be legitimate, under threat of exclusion from their *mutuelle*. In other cases, even if the employer has promised the worker he will not contest the claim, that has not prevented the *mutuelle* from appealing, in the name of the employer, any and all decisions taken with regards to the file.

The lawyers we met with, as well as many of the workers, described that when an employer contests a claim this often results in a poisoned work relationship, as the worker feels betrayed by an employer for whom he has worked for many years in a context that he believed to be one of mutual respect and collaboration.

“Before, [when talking about their law practice in the eighties]… when acceptance of a claim was at issue in appeal […] large companies would show up but small employers wouldn’t. Whereas now, with the *mutuelles*, more often than not we have small employers underfoot, whom we would never have previously seen. […] I think that now the phenomenon of the *mutuelles* antagonizes the relationship between the worker and the employer, which was not previously the case, because the *mutuelle* pressures the employer to contest claims because of experience rating. I’ve seen some files where the employer says to his worker, ‘Well, no, I’m not contesting; you’re clearly right; that’s obvious.’ And the worker says to me, ‘Yes, but my employer isn’t contesting.’ Well, I say, ‘Listen carefully, your employer has contested the claim, and that is why we’re going to a hearing.’ And he says, ‘But my employer didn’t contest.’ And I say to him, ‘He has to work it out with his *mutuelle*, because he’s given a mandate to his *mutuelle*, [to manage his claims] and the *mutuelle* has contested everything.’

### A no-fault system doesn’t mean no fault is committed:

- A worker lost the use of a leg after being hit by a 200 lb. log. He was repairing a part of a machine while another part was running, which violated regulations, but was a common practice at this company.
- In the context of seasonal labour in an outlying region, two waitresses worked 18 hours a day, 7 days a week. Their musculoskeletal disorders were not recognized by the CSST allegedly because the scientific literature doesn’t associate such injuries with a waitress’ work. There were no medical experts in the region able to testify to the link between the disease and the work.
- A worker became an invalid (severe cerebral impairment) as a result of carbon monoxide poisoning. This resulted from a second incident of intoxication caused by the same equipment which his employer had failed to have repaired despite the intervention by a CSST inspector after the first incident.
- Two workers lost their jobs and had their health gravely compromised by exposure to beryllium… a risk that should have been eliminated by the employer. This employer also failed to furnish the workers with information regarding the risks the exposure presented or even to inform them that the substance was used in their workplace.
- A worker hired by a sub-contractor of a very large foundry suffered from lead poisoning resulting from exposure at the site of the foundry and suffered serious damage to his cognitive capacity. The exposure took place at a foundry that was the object of a specific health program which included the regular measurement of workers’ lead levels in the blood, but over the years employees of sub-contractors had been forgotten and were not subject to the controls carried out by the public health doctors.
“Q: You’re pleading against the *mutuelle*? Is it the lawyer from the *mutuelle* who attends the hearing?
“A: It’s the *mutuelle’s* lawyer at the hearing.
“Q: And the employer, is he physically present?
“A: The employer attends the hearing because they need him at the hearing.
“Q: As a witness?
“A: As a witness. But because there is a distortion, because it’s not him, because it’s the *mutuelle*, you get the impression that nobody from the employer’s organization really understands what’s happening. And this antagonizes relations between the two, because the worker says, ‘Listen, look here, I’m in court and it’s you who brought me here.’ And the employer answers, ‘No, no, no, I agree with you.’ How many times have I said to the *mutuelle*, to its lawyer, ‘Where are we going with this file? Your own client says he isn’t contesting the claim.’” *Lawyer*

This polarization of relations can lead to irreparable antagonism likely to compromise return to work and the relationship between the worker and employer. The situation is exacerbated when the accident or disease results from employer negligence or the violation of occupational health and safety legislation.
Reclamations du travailleurs

- Identification du travailleur
- Identification de l'employeur
- Lieu de l'événement

Québec

悪いの

悪いの

悪いの
Without a doubt, making a workers’ compensation claim can both positively and negatively alter the way the illness is experienced and can produce both favourable and unfavourable effects on physical and psychological health. We will here summarily examine some positive and negative effects of the claims process and the factors that contribute to these outcomes.

**Positive aspects of receiving CSST benefits**

Workers acknowledged that receiving CSST benefits brings some relief, affecting both their physical and mental health. The beneficial effects of the system are optimized when the claim is immediately accepted and no conflict arises. When the claim is refused, or even accepted by the CLP at a later date, following a CSST or DRA refusal, which can entail years of litigation, the therapeutic benefits of the system are reduced; access to healthcare is postponed, and often the economic support comes too late to prevent the consequences of impoverishment. It is by comparing the situation of workers who saw their claim immediately accepted to that of those whose claim was refused that we can better understand the importance of the contribution of the system to the wellbeing of people receiving compensation.

**Access to healthcare**

Access to healthcare is certainly one of the advantageous aspects of the system most often stressed by the people we met. When the claim is accepted, the workers have rapid access to physiotherapy, acupuncture or occupational therapy prescribed by the attending physician. The cost of prescribed medications is covered by the CSST. In certain cases, this includes the cost of expensive treatments offered by specialized clinics (for example, pain clinics).

Under the Québec workers’ compensation system, contrary to the situation in Ontario and British Columbia, the CSST is bound by the opinion of the attending physician, notably with regard to the necessity for treatment. Like the employer, the CSST can challenge the opinion of the physician by following a procedure that requires evaluations by opposing experts, but cannot simply ignore the opinion of the physician who prescribes treatment. This translates into rapid access to treatment, even in cases where the CSST might have otherwise refused to bear the costs if they had the discretion to do so. Although these treatments are sometimes available through the public health care system, the waiting time for receiving them is often very long, while others are not publicly available and many workers don’t have the financial resources that would allow them to assume the expense of private insurance or the direct cost of treatment dispensed privately.

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4 The final appeal tribunal, the Commission des lésions professionnelles.
5 The internal review board of the CSST, the Direction de révision administrative
6 Diagnosis, treatment, consolidation of injury; functional limitations and permanent disability are all issues with regard to which the opinion of the attending physician is binding, under ss 212 and 224 of the AIAOD.
Workers in outlying regions repeatedly stressed the importance of having access to care from medical specialists, physicians to whom they would not have had access if the CSST did not assume travel expenses, thereby allowing workers to go to the city for treatment (respiratory specialists, ophthalmologists, neuro-psychologists, pain specialists, neurosurgeons, psychiatrists, etc.). The CSST covers travel expenses to the treatment service provider, thus providing workers with more independence from their families and, in certain cases, providing them with the maximum benefit from treatment, as regularity isn’t compromised by difficulties connected with travel or fees.

**The right to income replacement**

The economic support provided by «income replacement indemnity» (IRI) is of primary importance amongst the system’s positive aspects. Receiving IRI from the day the worker stops working assures the economic survival of workers and their families and reduces the stress related to an injury that compromises earning capacity. Some, not having access to CSST benefits, either didn’t stop working or returned to work prematurely, aggravating their injury.

“I waited for the CSST’s response, but… I didn’t get a response. I phoned the lady handling my file, but she was never there. Finally, I decided to go to work even though my doctor told me my arm wasn’t healed. But I needed money, so I went to work… I worked for a week, I forced my arm to work, but after a week, it hurt too much… It hurt more than before; I had a relapse. At that point, I stopped working and I filed another claim…”

When we compare this situation to the cases of those who received benefits from the outset, we can see how the relief offered by the acceptance of a workers’ compensation claim contributes to healing and protects, in the long term, the injured person’s working capacity.

Once the injury is healed, if the claimant is assured of receiving an income supplement (reduced IRI, based on a notional wage loss system) that covers a large portion of lost earning power, the worker feels reassured and encouraged to return to the job market.

The seven workers who had access to a social rehabilitation program (for example those who had personal home assistance or financial support for household maintenance) underlined the importance of this long-term support. It relieved certain worries and in some cases contributed to the preservation of family unity by providing recognition of the value of the enormous support of family care providers.

“A: It helps! It helps! When I speak about the level of confidence with the family, of authority in the family, from my point of view, because I think if I had no money, if I had no income, it would be a lot more difficult than it is with money. At the family level it’s fair; I have my income, my wife has her income, we’re equal as concerns money.”

The most seriously injured workers stressed the importance of being able to count on the CSST in the long term. Contrary to salary insurance, which rarely lasts more than two years, CSST benefits are available, at least in part, as long as necessary and the worker’s file remains open in case there is a relapse. Many workers we spoke with didn’t have access to any kind of salary insurance, even in the short-term; for those workers in particular, the existence of CSST benefits was extremely important to their wellbeing.

Economic support is really the cornerstone of the compensation system, an essential com-
ponent for those who receive benefits. We asked the workers how things would have been different if the accident had occurred at home:

“If it had occurred at home... I would have gone into financial ruin, and I probably would have had a divorce, or been up for murder. I'm serious. I'm deadly serious. The stress, if I did not have the antibiotics looked after by the CSST, which was a big chunk of it, financially, I would have been bankrupt.”

Information
For many injured workers, receiving relevant information about the law, their rights, the steps to be taken, the available resources, etc. considerably reduced the stress of the injury and the compensation process. Many of them stressed the importance of “having accurate information,” of “knowing what was going on,” of knowing “what lay ahead.” Some indicated that they had received this information from their CSST caseworker, but the majority had to turn to outside resources and some never obtained the information they required.

Support
Because victims of employment injuries sometimes benefit from a shared sense of community at the workplace, they, of all the people suffering from disabilities, have the best chance of accessing support, whether or not their compensation claim is accepted by the CSST. Many of the people we met with spoke of the enormous contribution of injured workers’ associations who provided accurate information, helped them to defend their rights and furnished the possibility of meeting other injured workers, thus providing opportunities for exchange with others and involvement that contributed to rebuilding their sense of worth and avoiding feelings of depression. Others benefited from the significant support offered by their union, without whom they would not have been able to face the demands of the claims process, much less to have successfully gone through the appeals process.

Some hospital employees stressed the help received from the liaison officer, whose function was to act as a bridge between the employer, the CSST and the worker following an employment injury. Others received services from the occupational health team at their local community clinic, which brought together workers suffering from the same illness and their families to allow them to discuss the impact of the illness on their lives in a group setting. This allowed them to share their experiences and break down the isolation.

The relationship with the CSST caseworker
The relationship established between the injured worker and the CSST caseworker is extremely important. An injured worker who feels supported by the compensation board caseworker does better psychologically and at times even physically. Some injured workers told us that their caseworkers had encouraged them not to return to work too quickly, explaining that a premature return could aggravate their injury. A victim of violence told us that receiving follow-up from caseworkers familiar with problems of victims of aggression provided substantial comfort and support during the healing process.

“The Montréal caseworker, I could tell by her behaviour, her actions, that she understood. After that... I had a caseworker in Québec City who had experienced violence herself... and who wasn’t... the social worker type, but she was really OK. And then after that, I had a caseworker who was a social worker, and who had a more social work approach. She was young and, I believe, she had values, and... in any case, an understanding of social problems and... wasn’t a bureaucrat... you know... Now I have a
new one who previously dealt with... trauma following bank robberies. That means that she has had clients with post-traumatic stress disorder. So I think she understands!

Other workers also stressed the support they had received from their CSST compensation caseworker who had encouraged them to consult a psychologist, the rehabilitation counselor who had facilitated access to training or the specialist in ergonomics who examined the workstation in order to ensure a safe return to work.

“I admit, for that, the CSST can be helpful. I had two caseworkers there, ... and an ergonomics specialist so that the working conditions at my job would be... would be OK this time... I was lucky she was there, [...] So my work station, if the specialist in ergonomics hadn’t been there... or the CSST, I wouldn’t have my adapted work station, that’s for sure; the first time, even though I was on CSST, my work station was not adapted. It’s because of the intervention of the specialist in ergonomics that the changes were made this time.”

Another worker, who still had pending litigation with the CSST following a second injury in 1998, feels that following her first injury in 1990, help from her caseworker significantly contributed to healing and return to work.

“Q: What’s the difference between your experience in 1990 and [the more recent one]? 
“A: [This time] I fell into depression, that’s the difference! The difference is that the first time... the attitude of the CSST helped, you must render unto Caesar what is Caesar’s; yes, they did things; they even paid for training that gave me... like a possibility of having another job. They also supported me in rebuilding my personal sense of worth. I felt like I was somebody to them... I always saw my caseworkers; I was always meeting with them... I came out OK after that injury because they supported me... You know, I was ready to start a new life and... I was feeling more... And I also had more money, eh! But this time, I know poverty again... Me, I have to tell you, I came out of the first experience stronger. But the second experience has demolished me.”

Respect
When a person feels heard, understood and respected, the effect is therapeutic, regardless of the outcome of the claim. When the caseworker speaks in a humane way, when the Appeal Commissioner listens attentively, when the decision rendered is personalized and clear, or when it emphasizes the worker's credibility, all of these factors reduce the workers' impression of being treated like an object or an economic burden and leave them more with the impression of having been treated like a complete human being.

Workers also appreciate the “no-fault” characteristics of the system and are comforted that no one tries to blame them for the accident for which they sometimes feel responsible.

In our related study of the system managed by the Société de l’assurance automobile du Québec (SAAQ), many victims of automobile accidents demanded a return to the previous legislation which allows for law suits against the responsible party. However, the injured workers we met with did not want to recover the right to sue the employer or co-workers whom they judged responsible for their accident. Nonetheless, despite the fact that workers' compensation is a «no-fault» system, as in the case of victims of automobile accidents who filed a claim with the SAAQ, many victims of employment injuries told us they felt they were blamed not only for having had an accident, but also for having filed a claim with the CSST.
Favourable conditions

Many people told us that the experience of filing a claim with the CSST could be a positive one if the file is correctly presented from the outset, if the attending physician sends the right forms to the right place without delay, if the employer provides accurate documentation of the worker's salary, if the diagnosis is unambiguous and uncontested and if the injury is the result of a fairly violent workplace accident. But when the employment relationship is precarious or non-standard, when the diagnosis is controversial or not provided in a timely manner, when medical specialists aren't available or when physicians don't want to deal with injured workers, when disability is caused by an occupational disease rather than a work accident with witnesses, when the injury doesn't heal as expected, when the employer contests the claim, when the likelihood of returning to work is unrealistic or non-existent, then conflicts arise, and the claims process and its resolution are liable to become an aggravating factor generating further health problems. We will now examine some health effects of the system and will then look at some of their causes.
Anti-therapeutic effects of the system

It can be difficult to clearly differentiate the consequences of an employment injury from the consequences of the compensation process itself. The injury is often the source of a loss of physical integrity, a decline in capacity and a deterioration of self-confidence, and may lead to a temporary or permanent absence from the workplace, pain, insecurity, stress and anxiety. However, at times the system created to attenuate these consequences can, instead, exacerbate them.

Being able to identify and tease out the consequences of the process from the consequences of the injury is very important to the development of strategies for preventing disability. Identifying the cause of the different parts of the experience of suffering that contribute to the development of disabilities is an essential step to prevention. The following table analyzing the sources of the fear experienced by injured workers shows how difficult it is to differentiate the different sources of the negative feelings described by workers.

<table>
<thead>
<tr>
<th>Sources of fear for injured workers</th>
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<tr>
<td><strong>The injury</strong></td>
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<tr>
<td>Unknown evolution of a life</td>
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<tr>
<td>threatening disease</td>
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<tr>
<td>Uncertainty about abilities</td>
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<tr>
<td>Family relations undermined</td>
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<td>by dependence and incapacitating</td>
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<tr>
<td>pain</td>
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<tr>
<td>Painful and dangerous treatment</td>
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<tr>
<td>Losing the respect of friends and family</td>
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<td>Loss of enjoyment of life</td>
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It may be difficult or impossible to eliminate the pain associated with certain injuries or to attenuate the consequences of life-threatening disease, but when an aspect of the process contributes to suffering, it is imperative that systems and those who study them strive to reduce these negative outcomes.

“My life, that’s what it boils down to, the experience with the CSST (laughs)… but it’s not because the system isn’t good. I believe the system is essential! That’s not it, but what I want to know is, ‘Why is it so complicated that I had to wait 5 years… for something that is so simple to establish!’ …”
Members of the research team had worked for many years, in various capacities, with people suffering from employment injuries so we expected to encounter anger, disappointment and sometimes depression during the course of our interviews. Nonetheless, we found the level of psychological distress manifested during the interviews alarming. More rarely, physical health seemed to have been compromised by certain aspects of the process. We will first focus on some of the effects on physical health before turning our attention to questions of mental health.

**Impact of the process on physical health**

The physical health problems of victims of employment injuries can be aggravated when a CSST decision deprives a worker of required healthcare or prescription medication or when the refusal of a claim leads to continued exposure to working conditions that aggravate the injury.

Many workers are deprived of treatment or have delayed access to treatment at different steps in the process: following a CSST refusal to accept a claim (often a recurrence of an initial injury), following a refusal by a physician to take on a patient making a CSST claim, as a result of a premature consolidation decreed by the Bureau d'évaluation médicale (BEM) or because of the limits on coverage imposed by regulation. Whatever the reason, this refusal of or delay in treatment can have consequences for the physical health of the worker; it may result in the deterioration or aggravation of the medical problem and, in some cases, may lead to permanent disability that could have been avoided by timely access to care and compensation. To counter these effects, some workers decide to personally assume the cost of treatment, but they often have to reduce the frequency and duration of appointments because of the limited resources at their disposal.

“[Following a recurrence] Then it took I don’t know how long before I could resume the treatments, it took 6 weeks… The physiotherapy centre, they finally told me that [my claim] hadn’t been accepted… But I didn’t receive any letters or anything like that; I didn’t know a thing! That it wasn’t accepted, well you know, right away, I got myself on the waiting list, but before I got an opening for physio, for that I had to wait another two weeks. Of course that’s a long time… And of course, because of that, you know, I had another relapse…”

“[…] I contested the decision when they refused to pay for the osteopathy treatments. [...] it took a year! A year to hear my appeal… for them to give me a reason. That’s the problem, that’s what I’m saying; you have to wait too long for the final decision. I didn’t receive osteopathy treatments; that’s the problem.”

**Impact of the process on mental health**

It is on the psychological level that the process causes the greatest damage. Some develop new disabilities, of a psychological nature, which in the long-term become more debilitating than the original injury. Sometimes the CSST will provide health care for psychological problems and they may give rise to a new claim, which will only be accepted if the worker can demonstrate that it was not the process that made him ill! The CLP, even more often than the previous appeal tribunal that heard appeals until 1998, the CALP or Appeals Commission, is inclined to refuse a claim for psychological injury if it is attributable to the process as such (Lippel, 2002).

- **Positive and negative feelings experienced by injured workers.** Sometimes it isn’t a question of developing new psychological “injuries,” but rather a sense of deep sadness,
Je souhaite pas ça à personne.

Vulnerable. Je ne vais pas cher la livre.

En colère.

La vie n'a plus de sens.
panic or despair. During the interviews, we indexed 93 different words for expressing the negative feelings evoked by workers in describing their experiences, whereas there were only 23 used to describe positive feelings. (see opposite)

• **Psychologically debilitating injuries.** When a serious injury affects a person’s sense of self, it is often the case that it not only affects that person’s physical state, but also his or her mental state. Some of the people we met with, whose claims were accepted by the CSST without difficulty, suffered from depression or anxiety as a result of the effects of the illness. On the other hand, many people, men as well as women, were treated for mental health problems attributable not only to their original employment injury, but also to the repercussions of their compensation claim itself. Some were hospitalized in a psychiatric facility as a result of these problems, others were outpatients and yet others remained silent about their psychological suffering for fear of inviting new difficulties and increased stigmatization. Excluding the four people for whom the original injury was psychological in nature, but including the people who both had considered suicide and who spoke to us of depression, fifteen women (40%) and eleven men (26%) told us they had had episodes of what they qualified as “depression” associated with both the injury and the process, or associated exclusively with the process. This count excludes the people (five women and seven men) who spoke of a “discouraging experience” and a fear of “having a depression” or who considered their depression to be solely the result of the injury.

• **Suicidal thoughts.** Four women (10%) and thirteen men (30%) spoke to us about their suicidal ideation. These numbers don’t include the people who were at pains to stress that they did not feel suicidal. These numbers were alarming because we had not asked questions about suicide. The lawyers we met with also raised this issue, explaining that the possibility of an injured worker/client committing suicide is a challenge they regularly face in their law practice.
4

What factors inherent to the compensation process lead to deterioration of the mental health of injured workers?

It is usually impossible on an individual basis to attribute the development of anxiety, depression or the desire to commit suicide to a specific aspect of an individual's experience, but it is possible, by listening to all of the testimony gathered from injured workers, to take note of the similarities in their experience and to establish points of convergence that allow for the development of collective strategies targeting specific changes that need to be made.

Three factors explained in large part the ways in which the compensation process negatively affected the mental health of injured workers: 1) stigmatization of injured workers, leading to a reduced sense of self worth, loss of self-esteem and feelings of guilt; 2) power imbalances, which engender feelings of injustice, frustration, vulnerability and impotence (these two elements are also associated with feelings of anger); 3) the absence of relationships of trust.

Injured workers: victims of accidents... and prejudice

More than half of the workers interviewed spoke to us, in one way or another, of the stigmatization associated with the status of injured worker, of the prejudice to which they fell victim, as if all injured workers were fraud artists abusing the system. The frequency with which this subject arose takes on great significance given that it was never raised by the person conducting the interview. Researchers who have studied the experience of injured workers in Ontario (Kirsh and Mckee, 2003), as well as others who have investigated the perspective of both workers and employers regarding return to work after a work injury (Eakin et al., 2003, 2005) raised similar issues.

What does it mean to stigmatize injured workers?

“Oh! So you're on CSST, eh! Since when? You don’t dare go there, you know; you don’t dare say anything... You mention it, it’s like you’ve got a sticker on your forehead. You’re marked, you’re an opportunist, but we know how much we suffer!”

[A victim of an occupational respiratory disease] “From one day to the next, everybody stops talking to you... I changed too; I'm not the same anymore; I'm not able to have fun anymore or to show others that I'm undamaged, that there's nothing wrong. I really do have something, but I don't feel bad... It's as if I was like I was before; I haven't got an injury that's causing me to suffer, but psychological pain, yes!”
Many people reported feeling they were being treated like criminals because they:
• suffer from a clearly recognized and diagnosed occupational disease, without external signs
  and thus which is “invisible” to colleagues and neighbours.
• suffer from incapacitating pain that cannot be measured and is therefore invisible to the
  CSST, the employer, physicians, colleagues and neighbours, and sometimes even to family
  members.
• made a claim to the CSST.
• received CSST benefits.
• attempted to have a recurrence acknowledged.
• tried without success to return to work.
• attempted to have their rights recognized through an appeal…

It is on the basis of the comments and behaviour of friends, colleagues, employers, private
detectives, compensation caseworkers, rehabilitation counsellors, attending physicians, med-
ical evaluators, lawyers and administrators, as well as the discourse advanced in the media,
that these workers conclude that they are perceived as criminals.

Remarks regarding this phenomenon were expressed in three ways:

1. Many denounced the injustice of being treated like criminals, of being the subject of sus-
picion and at times of even feeling as if they were being punished simply for filing a CSST
claim or for having suffered an employment injury.

   “I’ve thought about this a little bit, […] I’ve got a friend who is in the police in
Montréal and he said, ‘You know, there are a lot of fraud artists!’ I said, ‘Yes, me for
example, I spent all winter watching the war in Iraq on television. They went to war
because they say there are chemical weapons and all of that; that was their reason.
But I think that the CSST, to avoid accepting your claim, they say: ‘There are a lot of
fraud artists!’ You understand? But that’s not the truth! Because it’s people like me
who are hung out to dry, damn it! And I’m not a fraud artist! Do you understand?’

but

2. While many felt it a great injustice that they were treated like criminals, they found it legit-
imate that other injured workers were treated this way by the CSST, the employer or soci-
ety in general.

or

some felt that it was unjust to hold such a prejudice regarding injured workers who, after
all, were not welfare recipients… with all that that implied.

   “Q: What did you think of the CSST before you had your accident?
   “A: Before! Well, I can say that I knew there were people, but… it works both ways. I
know that they tried… It’s like a game between 2, 3, but… what I knew a lot about
was largely with regards to back pain. And a back, it’s like the guy in the end, he’s on
CSST because he’s got back pain, but he’s skidooning, and he’s 4-wheeling! You know,
at a certain point! You’ve got to understand [the CSST]! That, I’m in full agreement
with all of that! You know that’s playing both sides a bit! But in my case, it’s still…
my injury is obvious. I never thought I’d have problems like this.”
3. Finally, some completely espouse the widespread social prejudices regarding injured workers, and as a result feel guilty for having humiliated their family by having a work injury.

These prejudices regarding injured workers, often shared by the injured workers themselves regarding other injured workers, are widespread in their social circle; colleagues, parents, friends… contribute to the victim's social isolation.

“I often have people come into my office, and they say to me, ‘It’s my first time on CSST.’ It’s the social prejudice. They feel bad from the outset filing a claim and receiving CSST. The people who say that to me and who are collecting social assistance as well, they’ll say, ‘And social assistance, it’s the first time I’ve been on social assistance in my life.’ That’s common with people in their late forties, fifty years old, you know those that have always worked, who in some cases have children at university. Immigrants, I think it’s even more difficult for them, because they came here and they want the best for their children. Sometimes I find these people to be very fragile; they are really sensitive; even with me, one senses they are embarrassed. So, I imagine that faced with their workmates, they…; sometimes even in the workplace there is prejudice, ‘She or he doesn’t want to come to work.’ One time I visited [my client’s] workplace, and there were workers, you could feel it, they looked at the lady as if to say, ‘What’s she doing bringing her lawyer to our job?’ You feel it… there is prejudice and […] co-workers, the employer, it’s obvious; not all employers but some employers, it’s obvious. What we see are the cases in which there are problems. The problems are with employers; they aren’t only with the CSST caseworker.”* Lawyer*

**Video surveillance**

Video surveillance is certainly one of the most damaging practices for the health of victims of employment injuries, not only because it contributes to their stigmatization by confirming that it is legitimate to treat them like criminals, but also because it elicits for all injured workers a fear of leaving their homes and a fear of making full use of their residual capacities. The use of video surveillance by employers and the CSST is not only damaging to the person who is the object of the investigation, whether the video is subsequently introduced into evidence or not, but to all injured workers, who will self-censure out of fear of being subjected to further humiliation that would add psychological damage to the physical problems that are already preventing them from pursuing their activities (Lippel 2003a, 2005). In our study, the frequency of recourse to video surveillance varied from region to region. In certain regions, everybody we met had either been subjected to surveillance or personally knew somebody who had been filmed. Elsewhere, comments about surveillance were made by a few individuals who had had devastating personal experiences.

“We knew he was from a surveillance agency… [without knowing if the agency had been hired by the employer or the CSST]. It went on for a month, a month and a half, that kind of surveillance. The effect? I hid for 3 years. I was a shut-in; there was no way they were going to film me. I went into the basement, and there I made a group of friends by radio (high-frequency). A friend that I don’t see, I only hear his voice, he never sees me, he can’t judge me. For a 3-year period, I only spoke by radio and nobody saw me take a step and I stayed home; that lasted 3 years. Even now, if I see a vehicle parked for too long where it doesn’t belong, it’s not good…. right away I feel like I’m under surveillance. There’s no reason; my case with the CSST is resolved, but the feelings are still there. You can’t believe what it’s like to be under surveillance if
it’s never happened to you. It destroys a person like you can’t imagine! Because it’s a lack… it’s a lack of respect! It gets in; it’s a bit like it gets inside of us. And somebody who is under surveillance, it’s as if… the person under surveillance is a liar, is a cheat. The lowest of the low in our society, that’s what you are if you’re under surveillance… That pushed me almost to suicide, all of that stuff […] When I joined the Association [of injured workers] my claim had been settled, but I was reticent … because I was afraid to be seen by the CSST and to find myself being pushed around again. When you go through hell once, you remember it for a long time. The fear is always there! […]

Them, they don’t care; they want to save a few cents, that’s all… They don’t want to care for the human being. They’re trying to save a few cents. That’s what’s outrageous; it’s inhumane.”

**Fighting against a big machine: but which one?**

We met with many workers who told us that at each step in the process they “had to fight” against “the big machine,” “like David against Goliath,” that they were confronted by the “scheming” of the employer and the CSST, “of the union, the CSST and the employer,” “of the CSST and the CLP,” “of the employer’s physicians and those of the CSST,” “of all of the lawyers and the CLP conciliator”… In analyzing the circumstances to which the workers were referring when they spoke of scheming and the imbalance of power, we came to understand the degree to which they felt that a multitude of players were involved in making their experience more difficult. It isn’t necessarily the CSST as an institution that they are talking about when they speak of a “big machine,” but filing a claim with the CSST mobilizes the intervention of a number of parties, setting in motion a series of “big machines” that seek to control the injured worker, control his future, control costs, control his body, control his appeal, control the return to work process, control his behaviour at work, or at occupational therapy, or at the doctor’s office, and, in the case of clandestine surveillance, control his personal life and that of his family.

Aside from these issues, the most important element that arose in all of the interviews was certainly the existence of an enormous imbalance between the worker’s resources and those of the other players involved in the system, notably those of the employer and the CSST. When one or the other of these players contests the claim, there is already an imbalance. The employer has greater economic resources and exercises a hierarchical power over not only the worker, but also over his colleagues. The CSST also has significant resources, as well as access to information often unavailable to the worker.

“I [received] a paper to return to work…; I held two jobs. So, I was juggled between two bosses. So between two physicians and two bosses and the CSST, I was in the middle of the five. Five masters. I became very depressed; I consulted a psychologist…”

The workers are often aware that the employers finance the CSST, and some of them believe that this encourages the CSST to favour the employer. When both the CSST and the employer oppose the worker’s claim, particularly when the employer and the CSST appear together at an appeal hearing before the Commission des lesions professionnelles (CLP), each with their own lawyers and medical experts, the imbalance is even more striking. One worker we interviewed had been subjected to two separate episodes of clandestine surveillance by private detectives, one paid for by the CSST and the other by the employer. The adversarial climate that governs the workers’ compensation process is a key factor in the undermining of
workers’ health. Having to fight all the time, continually living with the stress of multiple contested decisions, as every CSST decision on any issue as well as every report from the attending physician can be the basis of a distinct legal challenge, all of this creates additional barriers for the worker who is trying to heal and regain his strength after an injury. Workers told us that the experience of a “CSST beneficiary” was sometimes more difficult than that of a person injured outside of the workplace.

“I realize that they do everything in their power to undermine me. I see the complicity between the employer, the CSST and the arbitrator… I see that they’re all on the same side. Now I understand that! I see that it’s one big machination. And it’s that that… that’s where I get destabilized. It doesn’t help your morale, when you see that everyone’s against you.”

Some injured workers count on the CSST to recreate a balance of power between the worker and the employer. There are times when these hopes are fulfilled, but often they are disappointed by the passivity or the complicity of the CSST with the employer, particularly when the time comes for the worker to return to work.

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**When there’s no one the worker can trust**

The third factor connected to the compensation process that seems to play a role in the development of mental health problems is the isolation and vulnerability associated with the absence of relationships of trust. Even if the process is filled with pitfalls, workers can come out of it relatively unscathed when they feel supported. This support can take different forms; a sympathetic CSST caseworker, family solidarity, a physician prepared to get involved to support the worker’s claim, a competent union that takes responsibility for the file, an injured workers’ association that brings injured workers together and demystifies the process, or a community clinic support group for workers suffering from the same illness…

But when a person can’t count on this kind of support, and when there’s no one she can trust to explain what’s happening, then the consequences of the pitfalls are much more serious. Those who come through the process unscathed are those who feel they have support and approval (from their family, their colleagues, other injured workers, sometimes even their employer) and who have a sense that they can trust someone to tell them what’s really going on, someone who can provide accurate information and explain the reality of both their medical and legal situations.

Breaking the isolation is an important therapeutic factor.

“Even the information meeting, where there were others … and where the lady that sat down next to me had more problems than I do or the fact that she’s had them a lot longer. Then I said to myself, ‘Ah, I’m not the only one!’ And there was a gentleman across from me who had trouble with a leg; and there was another who also had trouble with his back. ‘Ah, look at that, I’m not alone!…’ I needed to push myself a little harder, not necessarily to talk, but to know that there were others like me, that I was not alone, because I spent a year thinking that maybe I was the only one who had ever fallen down the stairs and smashed my head through a plaster wall…”

Access to reliable and competent resources is also important.
“Oh, good God, Madame! Yes, yes, yes, [the support of the union] is essential, yes, yes. It’s a card in my hand; yes, yes, it helps... Somebody all alone can’t survive that. You’re all alone? No, No! ... No, no, no, no, impossible! Impossible!”

“And often I wanted to give up during the claim, and [the union’s lawyer said, when the worker received a letter from the CSST], ‘Don’t worry; don’t read it! Don’t even open it; hide it in the corner; I’ll take care of everything!’ [...] If I hadn’t had her support, I would have long since... given up. Given my nature, I might have kept fighting! But when I was in a lot of pain, I couldn’t take it anymore. I would have dropped everything...”

Without these two forms of support, the experience proves extremely painful.

“...[T]he kind of solitude you live in, you have the impression that you have to live through all of that alone... and with your family, nobody wants to hear about it anymore. So, we can’t count on the people around us for help. After all they don’t know what you’re actually experiencing. And living with chronic pain, nobody understands that either. They think that we make things up; ‘Well no, forget it, you’re not going to win anyway, come on, you know!’ So nobody encourages you to continue...”

“You are overwhelmed by everything; you feel completely alone! I had no one to go with me, to back me up and say, ‘Did you notice that detail?’, or give me advice; you have nothing. You’re left on your own, and then you realize your union isn’t really that effective, but the majority of women, we don’t have the money to get a lawyer, eh!”
5

Actors and steps in the process likely to have an effect on the mental health of injured workers

Compensation board caseworkers

The quality of the relationship established with the CSST compensation caseworker has a decisive effect on the injured worker's experience. The caseworkers represent the organization and their judgment and behaviour will affect the case outcome. The front line worker is the first person from the institution with whom the worker has contact and, given the circumstances, the first CSST mechanism of control.

The CSST, as opposed to the SAAQ, allows injury victims to communicate directly with their caseworker; at the SAAQ the majority of litigants have little or no direct contact with their caseworker. Generally, the ability to have direct contact with a caseworker is appreciated by both injured workers and their representatives.

When the relationship with the caseworker is good, it constitutes a source of support for the injured worker and some of the people interviewed had experienced very good relationships with their CSST case manager. When the caseworker sees the worker as a person, respects his or her dignity, establishes a sincere exchange, truly listens and considers what is said, the relationship becomes a source of comfort for the injured worker.

It is also sometimes the case that the interests of the CSST and those of the injured worker coincide; for example, when it's necessary to accelerate access to hospital care. In such cases, the intervention of the CSST is appreciated.

“The date I was given for my surgery was November 2002. I then called my caseworker at the CSST and she said, ‘Whoa!’ ‘November 2002,’ she said, ‘No, no, no, no.’ I got called back by the hospital two days later, saying, ‘OK, your surgery is now August.’ So that’s a good thing about it – queue-jumping.”

Often the workers perceive their caseworker as omnipotent, when in fact, in some cases, their power is quite limited, circumscribed by the Act, regulations, directives, institutional orders, instructions from superiors and aspects of regional culture. When the worker is going through a difficult period and the caseworker refuses to act to resolve the problem, the worker's anger is first directed at the caseworker, which leads to conflict, particularly when the caseworker is unable to explain the decision, which is often the case when it is the result of an internal directive or a notice from the medical branch of the CSST. Once conflict arises it becomes difficult to re-establish a collaborative relationship. The worker will then distrust everything the caseworker says, and many workers have the impression that their caseworkers distrust them as well.
“My caseworkers, you can’t trust them when they lie to you; you can’t trust them any-
more. When you’re upset, it doesn’t take much for you to lose trust either… Your com-
pany that you’ve worked for for 13 years, they’ve screwed you. You don’t expect the
CSST to get you out of [the bad situation you’re in] when you know they work for [the
company]…”

Many of the caseworkers’ actions were the subject of criticism. Time and again, the people
we interviewed spoke of the flaws or gaps in the information they received. Workers
reproached caseworkers for not having provided them with the necessary information, for
having let them make mistakes or for not having been proactive in offering them information
that could have clarified their rights or shed light on what was to come.

In a few cases, workers felt their caseworkers had betrayed them by encouraging them to
do something that was later shown to be against their interest.

The way the caseworker’s job is organized has an effect on their relationships with injured
workers. Each is responsible for many files, and most of their work is done by telephone.
Some workers feel that if the caseworker were to meet them in person they would be more
inclined to believe them. It is rare that a compensation caseworker sees a worker. Many
workers have the impression that the caseworkers don’t understand the nature and condi-
tions of their work, and so have a mistaken conception of the circumstances of the accident
or of the conditions for return to work, which can lead them to make inappropriate, and
sometimes absurd, decisions.

The fact that communication take place on the telephone means that the caseworkers, by
this mode of intervention, enter the home unexpectedly, and some workers, particularly in
the case of complex and litigious files, feel their privacy is violated and that they are always
under surveillance. One worker told us he considered having his telephone disconnected to
protect his family from these unexpected intrusions (and from his own reaction to these tele-
phone calls).

It seems that the way the caseworker’s job is organized varies significantly from one region
to another. In some CSST offices, there is a large turnover of caseworkers; one worker has
met with 21 caseworkers since the beginning of his first claim, and another has had 34 over
a period of 20 years. These are doubtless exceptional cases, but many workers have had more
than five different caseworkers. The reasons for this turnover are not always clear, and the
workers perceive an unsolicited change in their caseworker as a form of punishment, either
punishing the worker for being too demanding or punishing the caseworker for being too
understanding. Obviously, the greater the turnover of caseworkers, the more difficult it is to
establish a relationship. Workers have to repeat their stories many times and often have lit-
tle time to re-establish the trust necessary for positive communication.

The workers who maintained a good relationship with their caseworker were often those
who could empathize with the system.

“The system is overwhelmed I’m sure, CSST, I’m sure that although I feel like I’m the
only one who’s in the system, I know that’s not true, and I know that agents have to
deal with not one or two or ten or twelve, but probably dozens of individual cases on a
daily basis.”

Many injured workers described the characteristics that they hoped to find in a caseworker;
someone who knows how to interact with people who are ill, who is empathetic, who applies
a presumption of innocence, who treats them humanely and respects their dignity and who is
proactive in providing detailed information. Workers’ representatives also stressed that many
conflicts arise between the injured worker and the caseworker because the latter responds to workers’ questions without sufficient reflection or without confirming the exactitude of the information. This is particularly true when the claim is complex, for example, when the case raises a controversy with regard to determination of pre-injury salary, multiple injuries with controversy as to aetiology, or when the very nature of the claim is controversial, as is the case with musculoskeletal disorders or psychological injuries. Misinformation generates a lot of unnecessary insecurity.

Some representatives believe that the distrust towards injured workers is systemic:

“With regards to psychological injuries caused by the system, I see two major sources; the first is organisational culture... When I speak of organisational culture, presumption of bad faith is almost... again I stress that I am speaking in general terms; I’m not saying that everybody is like that; that’s not what I’m trying to say. I’m trying to say that the system itself engenders this culture at all levels, and when I speak of all levels, I mean the caseworkers, the rehabilitation counsellors, the CSST lawyers, the regional physicians, the BEM\(^7\) physicians; it’s at all levels.” *Lawyer*

There are, as well, significant regional variations in this regard.

“In some regions, psychological injuries are rife, while in other regions there are no psychological injuries. For instance, there are a lot of psychological injuries in [regions x and y]. The inevitable conclusion is that the more the CSST is crazy, the more authoritarian the CSST is, the more controlling the CSST is in handling its files, [...] the crazier people become.” *Lawyer*

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**Physicians and the medical evaluation process**

Injured workers who suffer from employment injuries are first and foremost patients who require healthcare, and, for them as for other patients, the therapeutic relationship established with the physician is of primary importance. In a period of limited resources, they encounter the same difficulties as the general population in accessing quality medical services, while also facing some specific problems. On the one hand, just being a “CSST patient” can at times limit access to an attending physician and, in many cases, compromise the quality of the therapeutic relationship. On the other hand, precisely because of the key role played by the attending physician in the medical evaluation process, the scarcity of quality resources, particularly outside urban centres, leads to particular problems for injured workers, problems that go beyond the issue of access to health care.

The very fact of having made a CSST claim can affect the therapeutic relationship, and it is this aspect that we will first examine, before turning our attention to factors that specifically arise out of the medical evaluation process.

**The relationship with the treating physician**

- **Access to healthcare.** The fact of having made a CSST claim may have a positive effect on access to healthcare, but it can also compromise access. As we’ve mentioned, workers from the outlying regions stressed the significant advantages the system provides by per-

\(^7\) The BEM is the *Bureau d'évaluation médicale*, the medical arbitration board that intervenes when the CSST or the employer provides a medical evaluation that contradicts the opinion of the treating physician
mitting access to specialists in urban centres and by assuring more timely access to treatment when the CSST assumes the cost of healthcare.

On the other hand many workers explained to us that the very fact of being a “CSST case” made the exercise of finding a physician more difficult; many physicians tend to avoid “CSST patients” as a result of the bureaucratic demands and additional tasks these files require.

“He [the physician] could see that I was ill, but when I told him, ‘It’s because of my job,’ he said to me, ‘No, I don’t fill out any forms for the CSST. I know you’re sick.’ [he gave me all the necessary treatment], but when it came to filling out forms, ‘No.’”

“So I went to check out another physician who didn’t know me at all, and this physician didn’t want to get involved in any way. Because when it’s a CSST case, the physicians, they see the CSST, they don’t even know your name… It requires a big struggle, the CSST, and physicians don’t want to get involved… They don’t want to go near it… they don’t want to get mixed up in it. Even my physician, who knows me, who is ready to help me,… even he was reticent… I still had to argue with him!”

“Most of the physicians I’ve met, and me I’ve had a lot of accidents…, they’re not terribly enthusiastic about the fact that they’re industrial accidents. I think that they have to fill out a lot of paperwork, it creates a lot of obligations, and they’re pressured to send you back to work. [My orthopaedist], he told me that it’s a constant problem with the CSST. From the perspective of paperwork, the return to work, you know…, ‘Is he ready to go back to work? Can we stop paying him so he’ll go back to work?’"

At times, some physicians are reticent to provide healthcare to injured workers as a result of their own prejudices.

“I talked to my physician, and he said to me, ‘Ah, here in Québec, everybody…, the slightest thing, the smallest injury, and it’s the CSST!’ I said, ‘Did I talk to you about the CSST?’ and at that point I raised my voice. And I don’t even come from Québec; I don’t know anything about that, the CSST. So he said, ‘Whoa, don’t take it like that!’ So right away he presumes that everybody is… I said, ‘Me, I never did that, I never asked you for that… It was you who raised the question!’”

“You’re obliged to shop around, you’re obliged to suck up if you want a physician. They don’t believe it… a young man of 23, you know. The guy just wants a vacation, you know; it’s a bit like that. They get rid of a worker who comes looking for help, for medical support, very quickly, you know.”

Some injured workers have such a hard time finding an attending physician who is willing to fill out all the forms required by the CSST that they prefer to renounce their rights and give up the benefits of the system so as to obtain the healthcare they require immediately.

“She told me that she didn’t want any CSST cases, that she didn’t want anything to do with it… And all the physicians I spoke to… enough that at a certain point, I gave up the idea of claiming, because they didn’t want anything to do with the CSST… As soon as I said it was a work-related accident, that I got the back pain from my work as a homecare domestic worker: ‘No, me, I don’t treat CSST cases; I’m not interested…’ I got the impression that there were physicians who had been confronted by the CSST,
who were probably obliged to attend hearings... I went to see another physician, and I barely spoke about problems related to the CSST... I completely let it go. Certainly, that's a problem. I never talked about it. I always tried to hide my injury. I said to myself, 'Act like it doesn't exist,' to avoid... I never again had anything to do with the CSST or anything like that."

• **The therapeutic relationship.** The quality of the therapeutic relationship can itself be compromised by the existence of a workers' compensation claim. Some physicians have difficulty in assuming the dual role of healthcare provider and "gatekeeper" for the system and change their attitude when a patient whom they have treated for many years as a family physician becomes a "CSST patient."

Some workers reported that their physicians treated their CSST patients differently from their other patients with the same health problems.

Him [speaking of somebody else treated by the same physician for a similar injury], him because he had salary insurance, he had it easy. Him, he got his sick leave. And he was seeing the same physician! And this same physician didn't have the same attitude towards a person who injured himself at home and a person on CSST. It's clear in this case; I'm seeing the same physician! Him, he was put on leave for 3 months; they left him in peace. Me, he followed me and pushed me. It certainly wasn't the same attitude because there was pressure from the employer and pressure from the CSST.

Others described how the caseworkers and the CSST physicians can interfere with the therapeutic relationship that exists between the patient and his attending physician.

"After about 4 months, they changed my caseworker and the physician began to feel it was dragging on... He wanted me to return to work... or at least to try. I think that he sent me back to work in part because he was receiving pressure from the CSST. The CSST caseworker had communicated with my employer and my physician and all that, so I think from that end there was a certain pressure, which made him decide that I could return to work full time with no problems."

"The physicians, the physiotherapists, the occupational therapists get so much pressure from the employer that they send you back to work even if you're not doing well, even if you're not strong enough, even if there's been next to no improvement, even if you're doing really, really poorly, they send you back to work anyway. All of them told me, the occupational therapist, the physiotherapist, the physician, they all told me, 'We're sending you back because we're getting pressure from the employer, we're getting pressure from the CSST.'"

"He was so fed up with always having to fill out new forms, and all of his patients were always getting cut off. He said, 'They are constantly preventing me from treating my patients, the CSST... For me, that's it! With just those of you that I have here now from the CSST, I have enough work for the next 30 years! The CSST, I'm not taking any more [patients], it's over! [...] With them, it's always "Oh, I can treat someone for so many months, then I no longer have the right to treat them... So we have to use band-aid solutions while waiting for authorisation to treat them... OK, now I can provide treatment... They always prevent me from treating my patients; it's outrageous!'"
Finally, the medical evaluation process and challenges to the opinion of the attending physician call into question the credibility of the attending physician as a healthcare provider.

“The CSST sent me to see their orthopaedist… He told me I had healed by the end of September, but that I was going to continue having pain and that I should continue treatment until the month of January. So then I went back to my physician, because at a certain point, I no longer understood… Who does what? Who says what? And who’s right? And who should I listen to?”

Injured workers deplore the fact that they are no longer perceived as patients by the system, but as files to be managed and costs to be controlled. They feel that the therapeutic relationship has been removed from the system, that a claim and not a person is being treated.

“It’s always a battle of contestation. They don’t look at the facts. ‘OK, he’s injured; we have to treat him. We shouldn’t try to get him off benefits; we have to figure out what the problem is and treat it if it’s treatable.’ But that’s not what happens. It’s an insurance agency; the less we pay the better. The ones who don’t fight, good, we’ve got them! See, we’ve managed to put some money in our pockets. That’s how all injured workers feel. Because they don’t look at a guy’s injury, they look at how much it will cost.”

**The medical evaluation process**

Medical evaluation occupies a central place in the compensation process experienced by all injured workers. For many of them, it constitutes the system’s major stumbling block.

“Three-quarters of the problem is medical.”

“The big failure in all of this is with the doctors, that’s the big shortcoming.”

“It’s like a sort of war against the injured worker.”

Three broad categories of physicians play a role in the evaluation process, a process which can recur numerous times in the course of a single claim: the worker’s attending physician, the evaluating physician paid by the employer and/or the CSST and the physician from the Bureau d’évaluation médicale (BEM) who again examines the injured worker and arbitrates between the differing medical opinions that have preceded his evaluation.

- **The role of the attending physician in the medical evaluation process.**
  Injured workers have the right to choose the physician who will be responsible for their file and change physicians as needed (ss. 192 and 199, *AIAOD*), but many are ignorant of this fact and only become aware of it after having been bounced from one place to the next, from emergency wards to out-patient clinics, obliged each time to repeat their account of events and to undergo the same tests.

  Furthermore, particularly in outlying regions, this right often remains theoretical due to a lack of available physicians.

  “There aren’t any here [in the region]. We have trouble finding doctors, so I didn’t have a choice. The aggravation of filling out forms is something they want no part of… In other words, we can’t depend on them to help us proceed with our claims, not at all.”
“First of all, here [in the region], we don’t have physicians to speak of… We can't even really say that we have a family physician! You can't even say, 'I'll make an appointment with him,’ because it works like an emergency service. It’s a physician who is there every 15 days, at emergency … so we see him when he's there.”

“Who provides me with healthcare? It’s the traffic doctors at the CLSC8. Traffic doctors, by that I mean they’re there to say, ‘OK, where do you want to go? OK here you go, go there…’ He directs the traffic of patients. There’s one who’s there all week; the other is paid per service [à la carte].”

Even in larger urban centres, access to specialists may be just as complicated; sometimes there is only the physician who works at the emergency ward, who has very little time at his disposal and who is under a lot of pressure given the significant number of patients waiting to be seen.

This shortage of physicians affects injured workers in a particular way, as it can be a source of errors that are detrimental to the worker's compensation claim. Many workers shared with us details of legal problems arising from errors in medical files. A common problem arose because the physician recorded only one diagnosis in the file while verbally informing the patient that he suffered from several injuries as a result of the accident. These errors follow the worker throughout the entire claims process, creating a new source of litigation with all the negative consequences that that entails.

As we have seen, Québec workers often have difficulty finding a physician who will agree to take on an injured worker, but we also found that this phenomenon is as important, if not more so, in other provinces. During group interviews in British Columbia, representatives uniformly denounced this problem, a phenomenon that they attributed to the fact that the nurses working for the Workers’ Compensation Board can, at their own discretion, call into question an opinion of the attending physician. In these circumstances, few physicians are amenable to taking on a worker making a claim under the Workers’ Compensation Act. While acknowledging that many workers interviewed in this study had experienced highly adversarial situations relating to medical evaluation, in light of the comments from worker representatives in other provinces, it seems likely that the specificities of the Québec legislation with regard to the role of the attending physician serve to reduce conflict with the CSST.

The law specifies that the CSST is bound by the attending physician’s opinion regarding several medical issues, and, as we have indicated earlier, this provision has many positive effects, notably ensuring timely access to healthcare for injured workers. It does not, however, deprive the CSST of all discretion. In fact, this constraint is coupled with the right of both the employer and the CSST to challenge medical opinions of the treating physician at each step of the process and the law obliges the CSST to replace the opinion of the attending physician with that issued by the physician at the Bureau d'évaluation médicale, if it differs from the original opinion. Furthermore, the opinion of the attending physician has no particular weight with regards to many medico-legal issues, including causation of injury or recurrence of injury and ability to return to work.

Under the law, workers do not have the right to challenge the opinion of their attending physician, either that of a general practitioner or of a specialist; the underlying rationale being that the worker “chose” the physician. Often, no choice was really made, certainly not in the way that the employer or the CSST can choose the physician who will examine the worker on their behalf. In many cases the attendant physician arrives in the worker’s life “by accident.”

8 Local community health clinic, part of the public health care system available throughout Québec.
“Well, most of the time, we end up with someone we don’t know … What I understand from the CSST, if I consult him or I accept that he’s going to fill out a paper, I’ve chosen him. But it’s not like that! That’s not what really happens. I never chose him; he arrived in my life suddenly, and he took a piece of paper and signed his name. You know what I mean, I never chose him! It was him that… It’s like our paths crossed… But for the CSST, it was never that way. For them, I chose him.”

In spite of the difficulties that some encounter in their search for a good attending physician, injured workers are convinced that the physician who treats them, the one who offers the diagnosis, prescribes the treatment and follows the evolution of their injury, is the best placed to offer an informed opinion regarding their physical and psychological state and their ability to work. They don’t understand why physicians working for the employer or the CSST can intervene in the process at any time and question the validity of the attending physician’s opinion, most of the time for economic reasons, and often following a very superficial, and at times brusque, examination of the patient. Let’s now turn to what they told us about these medical evaluators.

The physician hired by the employer. Many workers were extremely critical of the examinations conducted by the physician paid by the employer to provide a medical evaluation. They spoke of a lack of respect and professionalism, medical reports remarkable for their omissions, inaccuracies or lies…:

“[The employer’s expert] said things [in his report] that were not true. He left out things that needed to be said and very much should have been said, but if he had have said them, they would have undermined things he wanted to say in his diagnosis. By omitting them, he avoided contradicting himself. […] That’s mediocrity, more than incompetence, it’s unprofessional, and it goes beyond that. It’s unethical! … I know that my employer, the fact that my employer sent me to a designated physician and paid $750.00 for an evaluation, it’s almost impossible that that designated physician is on my side or my attending physician’s side. He paid $750.00 for what then? What I mean is, that’s not normal. My physician who normally treats me, she doesn’t get any extra payment. The BEM, I don’t know, but I think even for them it’s less… The designated physician earns more than the BEM, because when I said that to the BEM, he said, ‘Oh, yeah, I should change places!’ (laughs) … First of all, I agree that the employer wants another expert opinion; that’s not what I disagree with. But give me an objective expert opinion! And if it’s him that chooses him and pays him, it’s obviously not objective. The physician is biased, there’s a bias there, it’s automatic…”

They denounce the fact that these opposing expert opinions don’t aim to understand their actual state of health, but serve uniquely to reduce the costs associated with the file while intimidating other workers who might want to file a claim.

“You always have to go to see the employer’s physician. They really harass you… It’s administrative, purely administrative, eh! They contest everything, everything, everything! All the time! It’s always like that because… it costs less when they contest. And there are people, half of them, when the claim is contested, they drop it! You know, they give up; they’re afraid.”

The physicians hired by the compensation board (CSST). As for the physicians designated by the CSST, they are mostly criticized for conducting hasty examinations,
which are perceived as nothing more than a pretext for the BEM to reverse the opinion of the attending physician.

“The physician, the neurologist who was designated by the CSST, he said that my sprain had healed … that I was able to return to work without any risk of adverse consequences, which was confirmed by the BEM; and the BEM, I was in his office for 8 minutes… To think that they make a rapid diagnosis, as rapid as that! The neurologist who was designated by the CSST, he only focused on my lumbar problem, and I went to see him for my cervical problem! He watched me walk, but he only focused on my lumbar. I was in his office for 14 minutes, and in the office of the BEM 8 minutes”

“With him [the orthopaedist designated by the CSST], I’ve got to say it didn’t take long; he examined me in 5 minutes. He told me that I didn’t require any more time because he wasn’t going to recommend continued treatment. For him, I had gotten all the benefits I could from treatment. He agreed it was tendonitis; he said it was true I had limitations, but treatment, he said it wasn’t good for me. It’s not him that’s suffering… Me, from my point of view, I need treatment.”

“They sent me back to see their orthopaedist again. And he wrote … according to him, in my case it’s … if I do have a herniated disc, it pre-existed the accident … and that’s my problem. It’s a pre-existing condition and degenerative or something… That’s probably what he writes every time for everybody, I imagine. You know, his cheque, it’s the CSST that sends it, you know!”

• The Bureau d’évaluation médicale (BEM) physicians. As to BEM physicians, with a few exceptions, it is difficult to see them as neutral physicians preoccupied with the wellbeing of their clientele. The examinations are often brief, sometimes brusque, and the bias in favour of the employer’s physician or the CSST's physician is perceived by many workers to be obvious.

“The BEM? That’s the worst thing that can happen, going to the BEM for an evaluation. Because they’re always going to tell you that you don’t have anything, because the CSST is always right, it’s always the physician who’s right, it’s never the patient. The pain, it’s me that has it… Me, I feel like I don’t have any rights, like I’m not human, I feel like it’s like I’m an animal… It’s always [the BEM physician] who’s in the right. Me, I have no voice, because when I say, ‘It hurts me here,’ he says to me, ‘No, it’s in your head, it’s not real.’ Even if he can’t say you’re lying, because of the doctor’s code of ethics, he finds other words to tell you that you’re lying…”

“What do they do [at the BEM]? They take the reports of others; they choose the ones they want, normally the employer’s. They transcribe them, they don’t do anything except transcribe them, and they side with the employer or with the CSST. You’ve got to believe they side with whoever pays the most. I don’t know how it works, but, in any case, it’s never, practically never, the real expert opinion that is chosen as… It’s always the one that unfavourably affects the worker. In everything I went through anyway…”

“[The BEM physician] said to me, ‘Listen carefully, little lady, to have a functional limitation recognized, you would have had to have an arm cut off. Thank you. Goodbye.’ I left and I felt like crying. And I said, ‘When they call us they say: Our physicians are
neutral, they don’t work for either the CSST or the employers, you have nothing to fear.’ When we arrive there, it’s totally the opposite; it’s enough to make you wonder if they’re working for the CSST and the employers; you wonder if they’re getting their palms greased to deliver reports that favour the employer… At the BEM in Québec City, it really made me furious what happened there; it was like I was a number; you’re not a human being there. And I personally think they must have made up their minds before they examined me… to give me an examination as fast as that… I didn’t have the impression that the physicians at the BEM were neutral… And maybe they [the CSST] should also accept fewer employers’ contestations. I think that the CSST should be aware of the game being played by the employer through his physician… and maybe they shouldn’t be so closely tied to the BEM, but more to the injured worker’s physician. The BEM and employers’ challenges, I think that that, that should be changed somehow.”

The workers we met with almost always felt at the mercy of the different appraising physicians and in no position to contradict these “experts.”

“They’re liars! [The evaluator wrote] objectively the patient doesn’t limp… I conducted this and that test on the patient and the patient didn’t complain of this or that pain. It’s easy for them, you know. Oh, it’s incredible; it doesn’t make any sense! What can I do as the little guy [ti-cul]? ‘Sir, you’re a liar!’ and accuse them of… that they play with the truth, that they say that it didn’t hurt me when they bent me forward, that I don’t limp when that’s completely untrue! But they write whatever they like and I don’t have the means, as a little guy, to fight that. I should tape them; I should have a witness. Them, they record everything. I don’t see why I don’t have the same right. No we’re left, at the BEM, we’re left alone, you know. At the CLP, that’s where we were able to stop the runaway train and back it up, because we lost the first 4 times at the BEM. The first 4 BEM were against me!”

Another worker was able to call into question the credibility of a physician hired by the employer and the BEM agreed with her. She could do so no doubt because she had the necessary knowledge to express herself in a credible manner regarding the quality of the expert opinion, as she was a nurse.

“…a letter from the CSST informed me that they were sending me for another expert opinion… an orthopaedic expert opinion. I went there… They didn’t really evaluate me there; they asked me questions… and when I received the report… the report was outrageous because there were parts in the report where they said they had evaluated things that they hadn’t evaluated. They said they conducted resistance tests, which they hadn’t done. They said that they had conducted such and such a test and it was fine, that I had performed adequately, which wasn’t true; I wasn’t able to do those particular exercises. I wrote a report with my comments, which I sent to the BEM… Listen, I have no problem with being evaluated, but evaluate me correctly! Evaluate all of the aspects that you should evaluate and report it in an appropriate fashion, in a professional fashion, according to the code of ethics. And if you don’t see anything, you don’t mark that you saw something or that you evaluated things you didn’t evaluate!”

Finally, it is important to note that specific adverse consequences affect workers in outlying regions because of the distance they have to travel when they are summoned to the BEM.
“Given that I already had back pain because I had to travel from Sherbrooke to Québec City, you know, I had a hard time toughing it out, as the saying goes. […] No, there’s no BEM in Sherbrooke. There’s one in either Montréal or Québec City. I think it depends on either the employer or the CSST, where they want you to go, and you don’t have any say in it. That meant that I had to pay someone because I can’t drive and experience the stress of driving to Québec City; it’s impossible. So I had to pay someone to come with me.”

**What do workers think of the medical evaluation process?**

It seems that the medical evaluation process is perceived by many workers as a cog in a giant machine that allows employers to control and reduce costs, to guarantee employment to a limited number of medical experts and to rid the system of unproductive workers who “are no longer worth anything.”

“You’re a number, and when your number comes up, there’s a little door that opens and you get off the treadmill and 2, 3 people make some money off of you, and everything turns again. And your number comes up again, whoops! So, you’re sent to another person and that fellow makes a little money off you; he ‘punches’ your card… click, click, you know… Three quarters, if not 7/8 of the people who are there, the machine will get them all, as far as I can tell.”

“You have to deal with a lot of doctors… Obviously, if they’re judged by results, they must certainly be appreciated, because it doesn’t cost much, when workers who are injured at work don’t receive compensation, well that doesn’t cost much! Good riddance, we won! And that’s not the purpose of the law; that’s not the spirit of the law!”

They have trouble accepting that the opinion of the physician treating them is set aside:

“Who are they to say that my physician does bad work? … It seems to me that he was evaluated by his university; he has his doctorate, and he has his specialty as well… Why always challenge physicians just to challenge them? They are always taking away the power of the attending physician for economic reasons, unfortunately. I think that’s the only reason, eh!”

“We have to have confidence in our physicians. Those guys aren’t twits! The radiologist, he’s not some little twerp… That guy, he’s not there to play games, and he doesn’t know you, and he doesn’t want to know you, but he is there to read what’s on the film. […] They themselves [the people from the CSST], when they’re injured, they’re going to be treated by those same physicians with complete confidence. Why is it that when it’s a worker … he’s going to be diagnosed by one of those doctors, but they don’t believe him! I don’t understand that; I still don’t understand…”

“You get the impression that from the point of view of the CSST or the CALP, that the opinion of the attending physician is completely erased from the file. He’s the person who is closest to the worker or the person who’s injured, who has seen and can determine the evolution of the patient’s injuries… They’re the people on the front line, the people confronted with the facts; they aren’t in any way complacent. So to see that they are perceived as complacent and that their opinion is treated with complete doubt and never taken into consideration. And the other one, the employer’s physi-
What does the medical evaluation process affect the health of workers?

Many workers complained of having suffered through a multitude of medical evaluations that had no therapeutic purpose, but were designed exclusively as a mechanism of control.

"There are too many intervening parties in my story, there are too many intervening parties. It doesn’t make any sense. Everybody gives an opinion!"

"There were weeks when I saw 3 physicians; that happened regularly. It happened to me frequently in the beginning that I had to see the employer’s, mine and the CSST’s. That was a real circus! To have 3 BEM, as well as the physicians..., I find that abusive."

"If my physician said to me, ‘OK, I’m sending you to a specialist,’ then they sent me to another specialist right after that. That’s how it works; I was evaluated by 23 physicians!"

The medical controversies and being continually convened for further expert evaluations are an important source of stress for injured workers who are already fragile as a result of the injury they have suffered.

"I think I saw 9 or 10… The employer’s psychiatrists, I’ve been to see 5 or 6, as well as the BEM’s two, and [mine] twice. It meant that I spent my time with psychiatrists, I spent my time … and that’s stressful, eh!"

"It’s very stressful, before it happens anyway. Way before, from the time you get the paper, and… before you go, that sometimes takes a month, a month and a half and… it’s a strange life you live during that period. In any event, the little bit I’ve experienced is already too much… with the BEM, with the physicians in Québec City; cases like mine have to stop… It destroys families; it destroys the people in any case…"

"But isn’t that stressful? As if you need that… You know, you experience losses; you experience losses at the academic level, at the professional level, at the level of sports, at the personal level, and then you have to hassle with them, on top of the pain! Shit, it makes you want to kill someone! You get worse, you know, instead of improving, I find…” [A woman who, exceptionally, received 3 positive reports from the BEM].

The experience with medical evaluations was seen as a source of physical and mental suffering for many workers. This worker, who had to submit to a multitude of medical evaluations, associates the process with her depression.
“He evaluated my ability to move my head, and he said to me, ‘Can you turn further?’ I said, ‘No, I can’t, it hurts me. I can’t.’ And then he took hold of me … he held me … he got behind me, he took hold of my shoulder, he took hold of my chin and he really forced the movement, and it was after that that I started to regress. My knees gave out … and I started to cry, and it really hurt! But then he said, ‘You’re faking, it’s not true!’ And in his report he said that I complained about any movement. […] I regressed even more because I lost the little progress I had managed to make before the evaluation. The little bit that I had managed to achieve, which gave me a little light – light at the end of the tunnel – disappeared; I had to start again from zero. Then I said to myself, ‘It’s not true that I’m starting again from zero! I’ve been doing this for two years…’ I was losing it! Then my physician said, ‘Whether you like it or not, you’re in depression!’”

Appeals and conciliation

The people we interviewed had experience with several appeal tribunals, some with the Commission des lesions professionnelles (CLP), a tribunal established on April 1, 1998, others with the Commission d’appel en matière de lesions professionnelles (CALP), the tribunal that heard cases between August 19, 1985 and March 31, 1998; there were even a few who had had recourse to the Commission des affaires sociales, responsible for litigation regarding employment injuries that occurred prior to August 19, 1985. Many workers had experienced two successive tribunals, even three in rare cases. More than half of the people we met with had undertaken an appeal to have their rights recognized, either as a result of a complete or partial rejection of their claim by the CSST or the DRA9 or as a result of an employer’s challenge after their claim had been accepted by the CSST. At the time of the interviews, 41 people had participated in at least one hearing or conciliation session and 10 others were in contact with the CLP and were waiting for a hearing. Others had not yet had problems requiring recourse to an appeal, but only 25 had gone through all of the steps of their claim without requiring legal intervention regarding their file. Of the people whose files had advanced sufficiently that they were in a position to tell us whether they had undertaken or would be undertaking an appeal, 74% of women and 57% of men required recourse to an appeal tribunal.

We were particularly interested in the appeal process because we wanted to know whether, for injured workers, the fact of undertaking an appeal or turning to lawyers or other representatives to plead their case has an effect on their experience as an injured worker. We also wanted to know whether male and female workers experienced this process in similar or in different ways. Some of the people we interviewed were recruited specifically to discuss their experience of an appeal hearing, while also sharing with us their overall experience with the claims process.

Analysis of the interviews allowed us to see that the experience of male and female workers was in many ways similar although there were also some marked dissimilarities.

Everyone who experienced an appeal found the process stressful, although the most stressful factors varied from one person to the next. For many, facing the unknown is a significant, destabilizing source of stress. It contributes to anxiety, particularly for women, who seem to be less familiar with the appeals process, having been exposed to the process neither by personal

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9 The DRA or Direction de révision administrative is the internal review board of the CSST. The caseworker renders a decision that may then be reviewed by the DRA either at the request of the worker or the employer. No hearing is held by the DRA and adjudication is based on documentation in the file. That decision may then be appealed to the CLP by any party.
experience or through the experience of colleagues. For some people, the level of stress was considerable, and they confided that they had seriously considered dropping their case, even though they believed they were right, because they were so afraid to appear before the tribunal.

The stress is attributable not only to the unknown, but also to the enormous significance of the hearing. Many people told us they felt their lives were in the balance at the hearing, so important were the consequences for them and their families.

**The experience of the hearing**

For many, being listened to, sometimes for the first time, by someone connected to the compensation system, had a comforting effect, particularly when they were able to say what they wanted to say, unimpeded by their own anxiety or by intimidation from the opposing party. Many emphasized the quality of the attention they got from the appeal commissioners, and the importance of this in reducing their stress. Some came out feeling validated, even before receiving the tribunal’s ruling. Most are proud to have “gone through it,” and, with exceptions, the workers we met did not regret having participated in the CLP hearing, even if, in some cases, the judgment was disappointing.

“It was nonetheless useful because it was the first time that attention was paid to the process that caused the injury … Personally, it was important to me to finally have the truth recognized. I can finally move on. The entire process was helpful to me, and, beyond that, I’m convinced that it also facilitated the settlement of another claim.”

The experience of testifying was, therefore, generally positive. However, some aspects of testifying and other facets of the hearing, particularly the cross-examination or the testimony of other witnesses, were often an important source of stress. For example, many felt that the lawyer for the opposing party did everything possible to trip them up, to make them contradict themselves, to raise questions about their honesty and to undermine their credibility. It was often in describing this part of the hearing that the people interviewed told us that they felt like criminals. The cross-examination often contributes to the stigmatizing effect of the process.

“…you seem, when faced with the employer’s lawyer, I seemed like a bandit, but that bugged me a little bit. And on top of that she asks questions, she comes back to the same questions, and she tries to say things you didn’t say… to try to confuse you. ‘It seems to me that earlier you said…’ And then you become, at a certain point, you become a little confused,… and you say… ‘It’s almost as if I seem like a guy who’s telling lies.’”

People for whom French is not the usual language face an additional concern, because they are afraid of expressing themselves incorrectly if they speak French or of being misunderstood if they speak English. (We did not meet with anyone who used an interpreter for the appeal).

For many, hearing the testimony of others was as stressful, if not more so, than testifying themselves, both because they felt unjustly attacked, but also because they were forbidden from immediately reacting to the remarks made. Some felt unsettled by the presence of the employer who had said he wouldn’t be attending the hearing or by the unfavourable testimony of a colleague.

“The [employer’s] physician said during the process that I was liar. And me, my fundamental honesty, my primary quality… I couldn’t take that; I left crying after the hearing! That he said that, it’s another stab in the back, a knife to the heart. That he said at the hearing that ‘The lady is a liar!’”
People don't always understand the composition of the tribunal, which in fact is composed of one commissioner, who has decision making powers, an employer and a union member, who have advisory powers only, and sometimes a medical assessor who advises the tribunal without having decision making powers. Many think that it includes a member of the CSST. The identity and the role of the union and employer representatives also remain perplexing to many.

“Me, I don't know if it's three commissioners or if it's people from the CSST… because I was fighting against the CSST. To me that means that there was someone from the CSST…”

The ruling obviously has a significant impact on workers' lives. When it is favourable, it raises self-esteem and legitimizes the claimant. When it is unfavourable, it often has the opposite effect. Nonetheless, the negative impact of an adverse decision is sometimes tempered by the commissioner's summation in cases where the ruling acknowledges the good faith and credibility of the worker.

“…they said at a certain point… that my testimony was very, very credible and that it wasn’t… There was no fabrication… there and that my [claim] wasn’t phoney, you know. I was happy as hell!… When they listen to you and it's just…”

In general, workers come away with a favourable impression of the commissioner who hears their case; but this is not always the case, particularly if the hearing is addressing a petition for review or revocation of a previous decision of the CLP\textsuperscript{10}. Even when informed of the nature of this “appeal,” workers don't understand that the commissioner is not interested in underlying issues, credibility, medical evidence, etc. They feel as if the institution isn't interested in the truth and are profoundly shocked.

“[The petition for review or revocation] A monumental farce!… Because… because the first [decision maker] has the right to make a mistake, but he hasn't violated the law. He made a mistake, but nobody cares.”

\section*{Factors that determine how the hearing is experienced}

The hearing is stressful for everyone, but the level of stress can increase when the issues at stake are important, when the power imbalance between the parties is important, when the waiting period before the hearing is long, when the hearing takes a long time and when the worker is ill prepared for the hearing.

The cost of a CLP hearing (representation fees, medical evaluations and reports, expert witnesses) are often huge. Very few people we met with were eligible for legal aid, almost exclusively those who were receiving income security (welfare). In some regions, lawyers were simply not available or were not familiar with the AIAOD. Some people had consulted an incompetent representative.

The costs assumed for the defence of a person in appeal started at $1000.00 for simple files, and reached $49,000.00 in a case where the aetiology of the injury was controversial. In the latter case, it was the union that assumed these expenses, and it is very likely that without this support, the worker's claim would not have been accepted in appeal. In many other

\textsuperscript{10} There are no appeals of CLP decisions, but in exceptional circumstances, a party may petition for the review or revocation of a decision under section 429.56 of the AIAOD, an exceptional proceeding that is based essentially on questions of law.
cases, the cost of representation and expertise represents a significant portion of the settlement. Some people we met with, lacking financial means or union support, were obliged to represent themselves.

In several cases, the worker was opposed by two other parties at the hearing, the employer and the CSST, both represented by lawyers and accompanied by medical experts in support of their challenge to the worker’s claim. Even for a worker who is receiving competent union representation, the power imbalance is flagrant. When the individual is non-unionized or union representation is absent or inadequate, the imbalance is even more glaring.

The experience of the conciliation process
Since 1992, the CALP, and now the CLP, have developed a conciliation service that has taken on an important role. Almost half of the CLP files are closed after conciliation, and these files were resolved, in most cases, by a waiver of the right to appeal, sometimes accompanied by a settlement agreement that escapes the scrutiny of the CLP.

We heard many comments regarding the conciliation process and its health impact on claimants. The point of view of the lawyers interviewed, who represent injured workers, is often different from that of the workers who participated in the study.

Lawyers believe that often the settlement obtained through the conciliation process is the best possible outcome for their client, particularly when the possibility of winning the case at a hearing is slight considering various factors specific to the legal process (availability of expert testimony or of financial resources to hire an expert, controversies in case law with regard to a key issue under litigation, the psychological fragility of the worker, which may compromise his or her ability to be understood, the number of days required for a hearing and the attendant expenses, difficulties in providing convincing evidence in cases involving a controversial diagnosis or an illness with multiple possible etiologies, ambiguities and contradictions in the medical evidence, all of these aspects considered in light of the offer of settlement proposed during conciliation). Lawyers often felt that they had achieved positive resolutions through conciliation in several cases that they believed they would have otherwise lost.

Some workers and some people working for associations defending the rights of injured workers told us that, from their perspective, the short as well as the long-term consequences of these agreements are not adequately clarified and explained to workers. An agreement that can seem beneficial in the short term may close off future options, and it is often the case that workers don’t understand what they are losing when they consent to a settlement.

Many of those who were exposed to the conciliation process said that they felt completely excluded from the exercise. In their experience, the process was more of an exchange between the representatives of the parties involved and the conciliators than a process meant to reconcile the parties themselves so as to allow them to continue working together.

The agreement reached through conciliation rarely gave the worker a sense of validation comparable to that resulting from the ruling of a commissioner who had really listened to them and judged them to be credible. On the other hand, conciliation allows the worker to avoid experiencing the stress of cross-examination and the harmful consequences of again having their honesty questioned. For some, the resolution is a relief following a long, exhausting process. Others continue today to wonder if they erred in accepting the proposed settlement or in waiving their claim, and sometimes, many years later, they still speculate about what might have happened had they chosen to proceed with the hearing.

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11 In 2003-2004, the CLP rendered 8251 decisions, ratified 3353 agreements reached through conciliation and achieved 7818 waivers of appeal following a conciliation session (to which are added 3041 so-called “natural” waivers); see CLP, Rapport annuel de gestion 2003-2004, Gouvernement du Québec, 2004.
When conciliation immediately precedes a hearing and fails, the destabilizing effect is magnified. One worker confided that his representative had insisted on postponing the hearing because, as a result of the conciliation process, he had become too angry to testify calmly. Others who went on to a hearing following a setback during conciliation were horrified when the lawyer for the opposing party brought everything into question anew in spite of admissions made during the conciliation process. Even if this behaviour on the part of the lawyer representing either the CSST or the employer is legal, from a human relations perspective the workers see this calling into question of facts already admitted to as undermining the credibility of the lawyers and the organizations they represent. This serves to exacerbate the frustration already felt by the worker as a result of the very existence of the litigation.

What differentiates the workers’ approach to a settlement agreement from that of their representatives is that workers who submit a case to the tribunal are seeking more than just a financial result. They seek to have their experience validated. They want the tribunal to recognize that they are not exaggerating, that they are honest, that their injury really stems from their work, that the suitable work they are being offered in their rehabilitation program isn’t really suitable and that they were right to have filed a claim or an appeal. A sum of money cannot, alone, fulfil all of these expectations. The hearing, on the other hand, can have disastrous consequences. When the worker loses the case, the ruling may underline the worker’s lack of credibility, conclude that his illness is of a personal origin, or confirm that he is capable of doing a job he knows he cannot do, etc. Such a ruling has a negative impact on self-esteem and possibly the mental health of the worker. It is often from these effects that the representative is attempting to protect the worker when he recommends an out of court settlement during the conciliation process.
Regional variations

Our research identified many regional distinctions. Workers who come from small communities are more likely to encounter their caseworker in daily life and often feel scrutinized. The lack of medical resources in outlying regions means that workers particularly appreciate the improved access to healthcare that accompanies the acceptance of a claim. However, when complex medico-legal issues arise, the lack of medical resources outside of the urban centres also implies extensive travel to access healthcare or to see specialists and complicates the preparation of their cases. In relatively unpopulated regions, specialists often work for the CSST, either as designated physicians or as medical experts, which can have a dampening effect on the quality of their relationship with the injured worker. In other cases, where the rare specialists refuse to treat injured workers or are incompetent, the impact on the injured worker can be much more serious than for those living in Montréal where alternate resources are available. In some regions, medical resources are non-existent for someone litigating a workers’ compensation claim. In others, it’s legal resources that aren’t available, even to those who can afford the expense. The available physicians and lawyers already work for the CSST and the medium and large employers.

Some of the CSST’s regional practices have a particularly detrimental impact on injured workers in small communities. In one outlying region, we met many injured workers who had been subjected to video surveillance, with the impact being felt by all workers. In this region, this strategy seemed more common than elsewhere and, because the community was small, everybody felt concerned by and fearful of this practice.

Injured workers’ representatives also stressed the lack of medical resources (psychologists and psychiatrists) prepared to treat people from the outlying regions suffering from psychological problems resulting from the process.

Workers who are precariously employed

Workers in non-standard employment situations often encounter specific problems in the claims process (Lippel, 2004). These people sometimes hold several jobs and extremely irregular work hours, making determination of their pre-injury income much more complex. Their professional retraining options are also more limited. In some cases, even an issue as simple as identifying their employer can become a source of litigation. The case for an occupational disease claim is often more difficult to prove, as the exposure to hazardous substances that cause occupational diseases is harder to document. Their rate of unionization is much lower, and their workmates, whom they often don’t know, are less likely to offer support when the time comes to present evidence of an occupational injury. We met one worker, a truck driver employed by a temporary employment agency, who, when his accident occurred, had to ask his wife to come several hundred kilometres to pick him up because the owner of the truck and the agency both insisted that the ambulance fee was not their respon-
sibility. These workers often experience greater financial pressures because they are in a more precarious situation than people who work full time for a single employer. People working for subcontractors, who may be exposed to various chemical products at different work sites, sometimes fall through the cracks of the protective mechanisms put in place by the CSST to prevent excessive exposure to toxic substances. Furthermore, the right to return to work in the case of a worker employed by a subcontractor is often illusory.

**Women Workers**

Although the rate of unionization of women workers who participated in the interviews was comparable to that of the men, the negative impact of an injury on income is greater for women than for men (Tables 3 and 4). More women than men saw their claim rejected (Table 1), perhaps because they were more often victims of occupational diseases (24% of the women interviewed) than was the case for men (11% of those interviewed). Some women told us that they felt at a disadvantage because they could not afford a lawyer, and we noted that women tended to be less familiar than men with the appeals mechanisms and the workings of the CLP. One woman described her preoccupations this way:

“It could be that it was worse because I’m a woman (laughs) not wanting to be sexist … because for them… […] when we say the man is the provider. Not so much now that women work, and now some women make even more than their husbands. But I have the sense that maybe we are possibly being judged, or I don’t know if perhaps I could say that claims by men and women are evaluated differently, because in my case it’s a second income. Because from the $414.00 I gross a week, from which 300 and something is left every week, it’s hard to make ends meet on that. We call that a casual income, but it’s not really an income. If I was a single parent […] obviously you can’t live on that.

“So I think to myself, maybe for them, it’s a woman, it’s not as important to resolve, it’s not urgent, she’ll probably give up or you know… She can stay at home. When it’s the man, what he brings in, he’s the number one provider in the household, so maybe that claim is more easily settled, I don’t know. But I don’t really doubt it, but I’d be curious to know the percentage of men and women who win. Because equal work, that’s not a reality yet, equal work and equal pay. So…”

Some women who participated in our study claimed for illnesses known to be exceptionally difficult to have recognized by the CSST because of the controversies surrounding them in the medical community; one was diagnosed with fibromyalgia and another with multiple chemical sensitivity syndrome. Others suffered from health problems clearly covered by the legislation, such as tendonitis and psychological injuries known to be associated with harassment, which, in spite of existing medical recognition and the clarity of the legislation, are frequently the subject of litigation at the CSST, and this litigation very often involves women (Lippel, 1992, 1999, 2002a, 2003; Pronovost, 2003; Fabris 2004). All these elements, whether of an exceptional or a systemic nature, serve to make women’s experience more difficult.

Existents stereotypes to the effect that women’s work is less demanding and less dangerous to the health (Messing, 1998) are shared by many of the players in the system. In some regions, we didn’t meet with any women workers. According to one well informed individual, “Women don’t have problems with the CSST in this region, apart from the fact that their claims are always refused.”
Immigrant, allophone and English speaking workers

While others have studied the particular experience of immigrant workers who file CSST claims (Gravel et al., 2003; Patry et al., 2005, Gravel et al., 2006), this was not an objective of our study. Nonetheless, the experiences of some people we met with led us to believe there is a need to more closely examine the way that this clientele is dealt with, particularly non-francophones. Overall their experiences are similar to those of other participants, but they also face specific issues.

Many workers feel they are misunderstood, and this problem particularly affects non-francophones, who not only fear being misunderstood, but also failing to understand. Anglophones have access to the relevant legislation and some pamphlets are available in their language, which is not the case for allophones. Nonetheless, when they receive their file, much of it is in French and they don’t always understand what they are reading. New immigrants know little about the claims system and nothing is in place to facilitate their understanding, at least in the case of the workers we met with. While many anglophone workers stressed the accommodating and even proactive approach of the caseworker, some among them still felt they were misunderstood and had themselves misunderstood things.

Some immigrant workers felt harassed, believing that the CSST caseworker was more vigilant in checking up on immigrant workers. Here’s an example:

“A: Because in the interviews they do, OK, when they figure out that we can’t express ourselves very well, they just ask other questions. They start to call you at home more often. ‘And I wish to speak to the gentleman; I want him to do something. I want him to come here.’ So, there’s more so-called harassment. I don’t know… if… in my case, that’s what happened. And anyway… I don’t know about other cases, but that’s how it was in my case. That’s why I say that there’s always… when you’re… when you’re not born here, they look for something to…

“Q: They called you more frequently?
“A: Yes, yes, yes.

“Q: To find out what you needed, or to put pressure on you?
“A: Actually, both I think, yes, both. To apply pressure, to find out, to prove… But if I’m at school, I can’t be at home. If I’m at the CSST, I can’t be… like that… I’ve had to leave many times actually, because … there was a caseworker that… The one from rehabilitation… he always wanted me to call and call, […]”

Evocative stereotypes from the age of the “Mediterranean syndrome” still seem to be current for some medical “experts.”

“The man from the BEM, he told me that the problem was that I come from a country where there’s a lot of war and the problem was in my head, psychological. That I was in pain, that it was always that way with everybody from my country. That this wasn’t a problem; that it wasn’t the hernia…”

It is important to note that one of the immigrant workers we met with, who speaks perfect French, stressed that he never felt any discrimination in his own case.

Some of the people we met with, who were born here and for whom French was their mother tongue, also experienced communication problems, including lack of information or failure to make themselves understood due to limited education or too large a gap in the level of
language used. These problems of communication, which touch many categories of people, create insecurity and confusion. In analyzing the problems and their solutions, it is important to keep in mind that language, ethnicity and degree of integration into Québec society are all distinct variables.

6. Particular issues that lead to additional obstacles
Recommendations:
What can be done
to reduce the negative
impact of the process
on the health of injured
workers?

The system shouldn’t encourage employers to contest
claims by injured workers

• Institutional practices create incentives for employers to “better manage” workplace health and safety issues, and, in particular, the legislative modifications carried out in the 90s to rules governing the financing of the system, have had the effect of promoting contestation, not only of the initial claim, but of each subsequent ruling throughout the course of the compensation process. Québec lawyers who participated in group interviews have noted a net increase in litigation over recent years, compared to the 80s, and stressed in particular the role played by the “mutuelles de prévention” in encouraging small employers to question and contest claims. Furthermore, claims are increasingly complex, and it is therefore more and more costly to have one’s rights recognized. The people we met with described again and again the injurious effects of questioning the legitimacy of a claim, a practice they often perceived as malicious and gratuitous and that left them feeling they’d been treated like criminals. The multiple medical examinations, which have no therapeutic objective, undermine the workers’ confidence in the system and the medical profession, and, in some cases, sabotage the therapeutic relationship with attending physicians. These examinations can also exacerbate an injured worker’s psychological and physical problems.

“Regarding psychological injuries caused by the system, [one of the sources] is the entire appeal system that leads to litigation that goes on almost infinitely. And beyond that, alongside treatment, alongside the compensation process with the CSST, there are sometimes several pending proceedings at a given time, at two appeal levels, and you get to a point, there’s a file that’s sent back to the CSST and there are others still remaining at the CLP; it’s incredibly chaotic.” Lawyer

• The institutional practice of systematically denying claims at the primary adjudication level, for certain types of injuries that will predictably be accepted by the CLP; contributes to adverse health outcomes associated with the process by delaying access to healthcare and by increasing the stress associated with disputed claims. This practice of initial denial seems especially common in claims regarding psychological injuries associated with chronic stress, certain musculo-skeletal disorders associated with repetitive work and relapses, recurrences or degeneration of previously compensated injuries.

In 2003-2004, the CLP opened 26,163 files and rendered 8251 rulings. In the same year, the Ontario Appeals Tribunal (Ontario Workplace Safety and Insurance Appeal Tribunal)
received fewer than 4000 appeals and had 4639 active files. Nonetheless, the Workers’ Safety and Insurance Board, the Ontario equivalent of the CSST, received more initial claims than the CSST. Elsewhere, interviewed workers’ representatives in British Columbia told us that, in their province, it is quite rare for an employer to challenge a claim or an issue related to a worker’s disability.

Refusing claims that are seemingly well founded, or encouraging employers to dispute claims, medical reports of attending physicians, individualized professional retraining programs and other aspects of the file, contributes to a more stressful process that is harmful to the health of the injured worker involved. Workers feel disrespected when they are obliged to repeat all of the information pertinent to their accident or related to the development of their disability, over and over again, to many different interlocutors, and in certain cases they feel that they are being completely consumed by the injury and the process because their condition is the subject of constant litigation, sometimes lasting decades. In the long term, in the case of many of the people we met with, the process contributed to the development of new handicaps, a state of disability that is inevitably expensive for the individual experiencing it and at times for the CSST or the State as well when the disability leads to compensation or gives rise to new healthcare needs.

### Practices that contribute to the stigmatization of injured workers must be avoided

- Measures must be taken to assure that all institutions and actors who intervene in the compensation process understand the consequences of stigmatization of injured workers. Any procedure that contributes to this stigmatization must be called into question (be it a media campaign, a training course for caseworkers, a cross-examination strategy, a strategy for disputing claims, etc.).
- Recourse to video surveillance should be subjected to the same rules that apply to video surveillance of people suspected of having committed a crime under the Criminal Code of Canada (Lippel, 2005). In all other cases, employers and the CSST should have no right to conduct video surveillance.
- Unions should pay particular attention to raising the consciousness of their members as to the importance of treating injured workers and victims of occupational diseases with respect so as to ensure that work colleagues welcome injured workers attempting to reintegrate the workplace and that the stereotype of the injured worker-fraud artist is eliminated from workplace culture.
- Injured workers associations should also continue their work in this regard, focussing on increasing awareness amongst their members and amongst injured workers about the negative effects of these stereotypes (which are sometimes expressed by the injured workers themselves).

### The power imbalance needs to be rectified

- For workers claiming workers’ compensation, those who also have access to salary insurance covering sick leave are far less vulnerable to the stress of a workers’ compensation claim. Injuries can be exacerbated when an injured person is obliged to return to work for economic reasons while still unwell. When the rejection of an appeal by the CLP or the waiting period before a hearing implies a complete absence of income and the obligation to
assume the costs of the appeal, the imbalance becomes unbearable and workers give up their rights, with the result that they feel justifiably disenfranchised and embittered. In Canada, 50% of employees have access to some form of salary insurance, but amongst precarious, temporary, on-call, part-time and seasonal workers, only 14% have this protection (Marshall, 2003). If all employees benefited from salary insurance (public or private) in case of illness, less would be at stake for workers in a CSST claim or a CLP appeal, and workers would feel less like they were gambling with their lives. Many European countries offer this sort of protection, while the financing mechanisms vary from one country to another. In all cases, the cost of employment injuries is entirely borne by the employer.

- The expense of representation and medical expertise renders illusory access to justice for a good number of injured workers. While the SAAQ reimburses the claimant for the cost of a certain number of expert opinions in cases where appeals are successful, no such reimbursement is available for injured workers. Employers and the CSST have far greater resources than workers; this absence of support is systemically prejudicial to injured workers and deprives them of their right to a full and complete defence. The expense of expert testimony produced by workers in the context of litigation at the CLP (or the DRA) should be subject to reimbursement when this expertise contributes to the tribunal’s deliberations.

- So that workers can have access to quality information coming from a source independent from the CSST, competent resources should be made available at no cost to injured workers regardless of whether they are eligible for legal aid. As the quality of the information provided by the CSST is often questioned by workers and, given the CSST is both a party and a judge when there is litigation, there is a need to provide workers with an independent source of information that benefits from a greater degree of credibility. This would no doubt contribute to reducing workers’ insecurity and vulnerability, as well as reducing the litigious nature of the process by providing workers with a realistic opinion as to their chances in appeal.

- The cost of worker representation should be assumed by the accident fund when the worker has to appeal to the CLP.

As we have seen, the legislature, in developing the existing rules for financing the system, made the choice to encourage the CSST to promote prevention by creating an economic incentive for employers to reduce the cost of employment injuries attributed to them. We have seen that many employers and mutuelles de prévention prefer to strictly control costs related to accidents by contesting claims and every issue raised rather than by investing in primary prevention, and we have noted the negative effect of this phenomenon on the health of claimants.

In the context of this study, we have also examined the case law with regard to claims for psychological injuries that one side or the other feels can be attributed to the process, and we have noted the conclusion of CSST lawyers and an important number of CLP commissioners (but not CALP commissioners) that these injuries cannot be the subject of compensation if the process is the determining factor in their development. In the current situation, employers are encouraged to dispute claims. This approach, even if abusive, with its negative consequences for the health of the claimants, is entirely beyond economic sanction. Workers (and in certain cases public funds) assume the totality of the cost engendered by illnesses resulting from the process.

The effectiveness of experience rating as a tool for prevention is still a controversial idea; the effectiveness of this policy has not been convincingly demonstrated (Thomason & Pozzebon, 2002; Tompa et al., 2004) and the harmful effects seem obvious in our study. Furthermore, when the system in no way provides for economic sanctions for unjustified disputes or abusive behaviour with negative and costly consequences for victims, we can then
speak of structural aberrations that encourage litigation and the potential abuse of power. In
Ontario, representatives interviewed told us that illnesses attributable to the process may be
covered by the system and increased costs engendered by abusive decisions or behaviours are
assumed by the system and, when appropriate, by the employer.

As is the case in Ontario, Québec must ensure that the cost of the consequences to work-
ers’ health of that which CLP case law refers to as “tracasseries administratives” or “adminis-
trative red tape” is assumed by the system. Only when workers are compensated will the
employers as well as the CSST have the incentive to consider the consequences of “case man-
agement” measures on the health of workers. Currently, this factor does affect the bottom
line, as recourse to harsh management, including systematic recourse to private surveillance,
leads to a decrease in payments.
In writing this report our objective was to provide the workers who participated in the study with an accessible synthesis of the results of our research, which, we hope, will also prove useful to others interested in seeing improvements to the workers' compensation system. It is impossible in a document such as this to present all of the observations contained in the thousands of pages of transcribed interviews. The testimonies therein constitute an important source of information that has served in the development of a series of articles and conferences exploring various aspects of the compensation system.

We did not prepare a chapter in this report dealing specifically with occupational rehabilitation and the return to work process, although this subject in itself could justify a detailed report. 33 of the 85 workers who participated in our study offered comments on diverse aspects of these programs, which some found particularly trying. The majority of their comments, however, were not about the health effects of the program; many people gave accounts of the difficulties encountered when they were looking for help in reintegrating the workforce and of their unmet expectations. The statements of workers about rehabilitation and return to the workforce are important and will be presented and analyzed in future documents, allowing us to better understand all of the dynamics at play in this process.

It is particularly important to address the fact that the concept of “rehabilitation” doesn’t appear to have the same meaning for everyone. From the workers’ point of view, a rehabilitation program should help them to find and re integrate the workforce in appropriate employment. In their opinion, it often happens that other players (rehabilitation counsellors at the CSST, lawyers, employers) see rehabilitation as a process that will permit the system to deem the worker capable of assuming “appropriate employment”, primarily for the purpose of establishing the amount of the reduced income replacement indemnity allotted to workers who are permanently unable to re integrate pre-injury employment.

Workers we interviewed came out of the process feeling degraded, sensing that they’re perceived essentially as expenses for the system and the employer, and not as human beings with the right to support in the return to work process. One worker expressed it this way:

“Q: How did the meeting with your counsellor and your employer go? How did you feel about it?
“A: I felt that… it was mostly at the end, when she said to him that if he didn’t take me back, it was going to cost him a lot. I found that bad. It was like saying, ‘Give her a broom to push, whatever, it’ll cost you less.’ I said to myself, ‘They’re having a damn good laugh at everyone, and right in my face besides that!’ […] She explained to him that he would have to pay me for the rest of the year; she explained all that to him in front of me… So you realize that you’re just a tiny object there… You know … I thought, ‘That’s something’ It was like saying, ‘Put her somewhere in a chair, at least it’ll cost you less. You’ve got to take her back! Wait a couple of months then get rid of her!’ That’s what it meant to me.”
The workers and the worker representatives who participated in our interviews, as well as staff from injured workers’ associations, our partners in this research program, helped us to understand that over and above the legal technicalities with which we were already familiar, there are many ways in which the system, designed to compensate workers, actually affects workers’ health.

The injured workers who participated in this study were very generous in sharing with us details of their experience, speaking both of their suffering and of moments of satisfaction. We are deeply grateful to all the people we met with, and we hope that the result of this research will serve to promote aspects of the system that contribute to the wellbeing of injured workers, and to improve aspects of the system that compromise the positive evolution of workers’ health or that may lead to new incapacitating illnesses.
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