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November 7, 2016

Mr. Rob Timlin
Vice President, Service Delivery Division
Workplace Safety & Insurance Board
200 Front Street West
Toronto, ON
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Dear Mr. Timlin,

RE: "Better at Work" Critique

Thank you for your response to our correspondence from July 21, 2016, where we laid out a critique of the Board's "Better at Work" approach. While ONIWG appreciates the time you took to respond to some of the issues we raised, there are still many outstanding questions that have not yet been answered. Fundamentally, we remain deeply concerned that "Better at Work" sacrifices the "safe" part of "early and safe return to work," and injured workers across the province are suffering because of this. In effect, "Better at Work" could be renamed the "Work in Pain" approach, as this is what it means in real terms for too many injured workers.

Fundamental differences

In your response, you state that the Board's current return to work practices and protocols maintain the same principles that were previously outlined in the *Recognizing Time to Heal* document. However, in reading and comparing the Board's newer return to work documents – *Better at Work* and *Return to Work Considerations* – with the previous *Recognizing Time to Heal* document, it is clear that the newer documents are indeed fundamentally different in tone and emphasis.

For a stark example, we can look at the fact that *Time to Heal* explicitly recognized that "there are cases where 'rest' is an appropriate form of treatment and required in order to speed recovery and facilitate a successful return to work." Conversely, the new Administrative Practice document says "evidence-based best practices do not support 'rest' and inactivity for promoting recovery and supporting successful return to work."

The *Better at Work* document, for its part, makes virtually no mention of situations where time to heal must be respected. The only acknowledgement that immediate return to work may not always be possible is in the last sentence of the document. And even there, the point of that sentence is to say that even if immediate return to work is not possible, there should still be early efforts at starting the return to work process.

The above are examples of the overall difference in tone between the *Time to Heal* document and the documents associated with the "Work in Pain" approach. In the former, there is an appreciation that sometimes injuries do require time to heal. In the latter, though, there is no recognition of this nuance.

It is also worth noting that premature return to work issues were one of the primary issues identified in the *Prescription Overruled* report. In that report, injured workers' treating doctors explained how, with increasing frequency, their patients are being pressured to return to work before they are medically fit to do so, and in contravention of medical evidence. Treating healthcare professionals, then, have also noticed a shift in the Board's return to work practices in recent years.

If, as you state in your letter, the intent of the new documents is to keep the same principles that were in place under *Time to Heal*, then one must wonder why it was necessary to introduce the new documents at all. One would assume that there must have been some desire for change; otherwise there would be no impetus to replace *Time to Heal* with a set of new documents.

Opposing research not addressed

In our original correspondence, we cited numerous research studies that substantively challenge the "Work in Pain" approach from various angles. For instance, we quoted papers from Dr. Ellen MacEachen, Dr. Gordon Purdie, Dr. Michael Lax, Dr. Joseph Ladou, and Etches, Mustard, et al.

It is disappointing that your response does not engage with any of this research. The extent of the opposing research demonstrates that there is no consensus around the "Work in Pain" approach, and it calls into question the claim that the approach is "evidence-based." In fact, as we pointed out in our original correspondence, the ACOEM itself acknowledged that its suggestions are not fully supported by systematic and formal research.

The lack of consensus around the "Work in Pain" approach is perhaps most clearly exemplified by Dr. Katherine Lippel, who states in a September 12, 2016 *Toronto Star* article entitled "WSIB policy pushes hurt workers into 'humiliating' jobs and unemployment, critics say," that the flaws in the Board's current return to work program are "not morally right – and it's not good science."

We would therefore appreciate a fulsome response that meaningfully engages with the material we have cited, and explains why the Board prefers the "Work in Pain" approach despite the preponderance of research challenging it.

Stigma from ACOEM

Relatedly, we were hoping to hear an explanation as to why the Board has chosen to rely on an organization – the ACOEM – that has clearly stigmatized injured workers. Perhaps the clearest example of stigma is Dr. Jennifer Christian's cartoon about injured workers, which we included in our original correspondence. This is insulting and hurtful to injured workers, and in our view, it reflects an ideological bias against injured workers, rather than a serious scientific exploration of research and evidence. We would expect our compensation system to support injured workers against insinuations like this. Instead, the Board has gone ahead and uncritically adopted the policy proposals from the stigmatizing organization.

Questioning the "evidence-based" assertion

In addition to the opposing research we have cited above, it is also difficult to understand the Board's assertion that "Work in Pain" is evidence-based, when the Board itself has acknowledged that it does not track actual return to work. Indeed, in the September 12, 2016 *Toronto Star* article, the Board provided a statement saying it "does not systematically follow up with injured workers following their return to work."

This begs the question of how the Board can provide honest assurances that its return to work practices is effective, when it does not track real-world outcomes. If the WSIB does not know whether injured workers have actually been able to sustain work, then how can any "evidence-based" conclusions be drawn about its programs?

In effect, we feel that the Board does not release actual return to work outcomes because the reality is that the outcomes are so poor. The return to work stats from the one-year post-injury mark, which the Board does cite, are convenient because injured workers and employers are put under incredible pressure to ensure that injured workers are working at that mark. However, there is no evidence that the Board is interested in what happens afterwards. Perhaps this is because it is known that a large percentage of these injured workers are not able to continue working – either because they cannot do so for medical reasons (i.e. the return to work was too early and not safe), or because the jobs were not real or meaningful in the first place.

In light of our concerns, we would appreciate it if the Board could send us the methodology it uses for tracking injured workers' return to work outcomes.

Principles & discourse around "Work in Pain"

In closing, it may be worth re-emphasizing why we are so concerned with the "Work in Pain" approach. Fundamentally, it is because it implies a one-size-fits-all methodology. Even if this is not the intention of the protocol, this is how it is being implemented in practice; no matter how severe the injury, the solution is presumed to be a quick return to work.

To state that the faster someone is able to return to work, the less likely they are to suffer long-term injury consequences, is simply to reflect the reality that the people who are able to get back to work faster are the people who have suffered less severe injuries in the first place. For this

demographic of people – the majority of workplace injuries – an early return to work strategy is not a problem.

However, when the "Work in Pain" approach is applied to those with more severe or complex injuries, the result is not likely to be a successful or sustainable return to work. These people will need more support and a longer time to heal. Unfortunately, it is this demographic – the much more vulnerable demographic – that is re-victimized by an overly aggressive scheme that pressures them to return to work before it is safe to do so. This is the troubling effect of the "Work in Pain" approach.

The discourse around "Work in Pain" also suggests a sort of false binary; it implies that either someone should return to work quickly, or they will just be staying home and their physical and mental health will deteriorate. The reality, though, is more complex than these two implied options. While a fast return to work may be appropriate in some cases, there are also situations where people simply need more time to heal. They need to be provided with the appropriate supports in order to heal, and they need to be supported without the pressure of being prematurely sent back to work before it is safe to do so.

In practice, "Work in Pain" does not allow for this support. As a result, this approach has the opposite of what you state to be its intended effect, as it puts people in situations that cause a deterioration of their physical and mental health.

Solutions

In light of our critiques of the "Work in Pain" approach, we would like to reiterate the proposed solutions we outlined previously:

- Abandon the "Better at Work" principle and document, as well as the link to the ACOEM 2016 Report;
- Return the Time to Heal Best Practice and elevate it to the Operational Policy Manual;
- Reject the stigma of injured workers inherent in the ACOEM and in the "Better At Work" document;
- Improve decision making by elevating the importance of the treating health professionals' opinions;
- Put the injured workers in the process at all levels. Reinstate the voice of injured workers in the clinical setting;
- Regularly monitor the experience of injured workers after they return to work or are deemed to return to work.

We look forward to your response.

Sincerely,

Steve Mantis
Chair, ONIWG Research Committee

CC: Kathleen Wynne, Premier
Kevin Flynn, Minister of Labour
Elizabeth Witmer, WSIB Chair
Tom Teahen, WSIB President & CEO
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