DOLDEN WALLACE FOLICK LLP

ENFORCING MANDATORY REHABILITATION CLAUSES

PAPER FOR 4TH ANNUAL DISABILITY CLAIMS MANAGEMENT AND LITIGATION CONFERENCE

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October 28, 2011

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I. INTRODUCTION

Disability insurance policies often include mandatory rehabilitation clauses requiring disabled insureds to make reasonable efforts to rehabilitate themselves and thereby avoid the imposition of unnecessary loss on their insurers. Such policies may require insureds to undergo treatment, accept medical supervision, participate in rehabilitation programs, and retrain for alternative employment. When insureds do not fulfill their contractual obligations under such policies they risk the reduction or even termination of their benefits.

I. PURPOSE OF REHABILITATION CLAUSES

Mandatory rehabilitation clauses are consistent with and reflect the general duty imposed on injured persons to mitigate their damages. In 1985 the Supreme Court of Canada in *Janiak v. Ippolito,* [1985] 1 SCR 146, concluded that an injured person must undertake reasonable medical treatment, which may well include invasive surgery, in order to mitigate their injuries. In *Janiak* the recommended operation offered a 70% chance of success and, if successful, there was a 100% chance of recovery which would allow the plaintiff to return to work. The court determined that the defendant successfully met the onus of proving that it was unreasonable for the plaintiff to refuse the surgery and thereby mitigate his losses. The court reduced the plaintiff's award by 70%, the success rate of the operation.

Janiak was decided in the tort context, rather than the contractual context of a disability insurance policy. However, its reasoning on mitigation has been widely applied in insurance cases considering whether a failure to comply with rehabilitation clauses might result in a reduction or termination of disability benefits: *Sander v. Sun Life Assurance Company of Canada*, 2001 BCSC 1445, affirmed 2003 BCCA 55; *Birt v. General Accident Assurance Co.*, 2003 PESCTD 13.

A typical example of a rehabilitation clause is found in *Sander*:

> ***MEDICAL TREATMENT*** *A Participant must receive appropriate medical treatment beginning with the onset of the condition involved and continuing throughout both the Elimination Period and any subsequent payment period. This will normally mean treatment that involves more than examination or testing. It must be reasonable and customary, performed or prescribed by a Physician or, whenever considered necessary by the Company, a medical specialist. Treatment must be carried out as frequently as the condition requires.*
>
> ***PARTICIPANT'S RESPONSIBILITIES WHILE DISABLED*** *During any period of disability, the Participant must make reasonable efforts to:*
>
> *(a) recover from the disability, including participating in any reasonable treatment or return to work assistance program.*

It is important to distinguish between rehabilitation clauses on the one hand and clauses that import a regular medical care requirement into the policy's definition of "disability", "total disability", or similar terms. Rehabilitation clauses only apply to insureds who are within coverage, *i.e.*, disabled; they impose a duty on the insured to take reasonable steps to mitigate, and thereby continue receiving benefits. An insurer who wants to demonstrate that the insured is *not* complying with the clause will likely bear the burden of proving that the insured is acting unreasonably and failing to mitigate. Definitional clauses, by contrast, require an insured demonstrate that he or she is receiving regular medical attention, and is thereby entitled to coverage at all.

II. MEASURING COMPLIANCE WITH REHABILITATION CLAUSES

To determine whether an insured has complied with a rehabilitation clause (or, more generally, a duty to mitigate by seeking out treatment), courts will assess several factors, including:

- the nature and purpose of disability insurance;
- whether a reasonable person, assessed objectively, would undergo treatment; and
- whether there are subjective reasons for the insured not to undergo such treatment.

A. Nature and Purpose of Disability Insurance

When an insured makes a claim under a disability insurance policy, he or she likely has significant health problems and may no longer be capable of working. This can give rise to a power imbalance between the insured and insurer, a consideration that affects the judicial interpretation of rehabilitation clauses in disability insurance contracts. The courts are aware that disability insurance is intended to protect insureds precisely when insureds are likely to be particularly vulnerable. Policy wordings are thus interpreted liberally in accordance with the intent of the parties.

The courts are aware that the insurer has the opportunity to craft the language and define the terms of the contract. Further the purpose of insurance is to protect insureds in time of need. These concepts have led the courts to interpret any ambiguous language in favour of the insured, a principle known as *contra proferentem*. Therefore, it is important that insurers are very conscious of the type of language they use and be cautious to be as explicit as possible when imposing limits on benefits.

The example of the application of *contra proferentem* in the disability insurance context is found in *Brown v. Canada Life Assurance Company,* 1996 CanLII 7246 (NBQB). In that case, an insurer argued that the benefits payable to its insured should be reduced by 50% because the insured was not following medical advice to quit smoking and drinking, and to improve his diet. The Court concluded that it was "probably almost impossible" for the insured to stop those habits, and that, had the insurer wanted to avoid paying benefits in such a context, it could have put in its policies specific exclusions for failure to follow such advice.

B. Whether Proposed Rehabilitation is Reasonable:

When courts assess what constitutes an objectively reasonable treatment decision they balance the perceived risks against the potential benefits. This assessment also considers the consequences of not undergoing this treatment.

These principles guide the analysis in this area of the law. In *Chrisgian v. Schimpe*, 1997 CanLII 3499 (BCSC) the court reduced the plaintiff's award for damages by 50% because they determined the plaintiff consistently and unreasonably failed to follow his rehabilitation exercises which would have facilitated complete recovery. Conversely, in *Sandhu v. Kuntz*, 1996 CanLII 1164 (BCCA) the court determined that the plaintiff acted reasonably when he refused to undergo a surgery when the medical opinions were inconsistent. However, the court did reduce his damages because he failed to retrain for alternate employment through a rehabilitation program and re-enter the workforce within a reasonable timeframe.

The plaintiff in *Sander* refused to undergo cataract surgery because there was a two percentage chance of complications with the surgery which included 0.3 percent chance of blindness. Sun Life determined they were willing to extend benefits for a period that would allow him to undergo surgery and recover. Sun Life then informed the plaintiff

they were terminating his benefits after that time period elapsed regardless if the plaintiff underwent the surgery or not. The plaintiff booked but never attended surgery and sued his insurer. Given the low risks and prognosis of full recovery, the court determined that refusal of the treatment was unreasonable.

In *Yphantides v. McDowell,* [1985] 1 WWR 422 (MBQB), the plaintiff's physicians recommended surgery to address a disc protrusion. The plaintiff refused surgery and alternate treatment options on multiple occasions despite multiple doctors' recommendations. Her medical practitioners highlighted the benefits of addressing the plaintiff's symptoms but the plaintiff consistently refused treatment. The court determined that this pattern of obstinance and its effect on her health warranted a 50% reduction in her general damages.

A court may in some cases conclude that an insured has reasonably refused to participate in some form of rehabilitation if, for example:

- there is a conflict of opinion between the treating physicians as to the utility or risks of the proposed treatment (*Birt*, at para. 98);
- there is a serious risk of complications that outweighs the potential benefits; or
- the insured has not been adequately informed about the risks and benefits of the treatment.

It is also likely that an insured can refuse to participate in rehabilitation measures that are not likely to produce any benefit. In *Kirkness Estate v. Imperial Life Assurance Co. of Canada*, [1993] OJ No. 160 (QL)(ONCA), an insurer required that the schizophrenic insured attend a psychiatrist as a condition to recovering benefits. The benefits were terminated when the insured rarely attended his psychiatrist. The Court determined that treatment would not result in rehabilitation, that strictly enforcing the contract

would therefore undermine its purpose, and was unwilling to conclude that the insured had breached the contract.

C. Subjective Reasons not to Mitigate

Sander a case specifically on mandatory rehabilitation clauses, followed two earlier cases concerning mitigation and found that subjective criteria must be utilized in determining the insured's contractual obligations. One must consider the unique circumstances of the insured. For example, as noted above, in *Brown* the Court held that the insured likely could not break his habits of smoking and drinking, and thus could not be faulted for failing to follow medical advice against those habits. This will be a question of fact in every case, however; for example, in *Cowie et al. v. Mullin*, 1992 CanLII 4585 (NS SC) the court reduced the plaintiff's damages by 10 % for his failure to lose weight under physician's instructions.

The courts assess the overall attitude and behaviour of the insured. If the insured is generally compliant with instructions from treating physicians, refusing one specific treatment may not be considered unreasonable. In *McGinn v Seaboard Life Insurance Co.* [1992] NJ No. 58 (QL)(NLTD), the plaintiff refused an eye implant. The court noted that plaintiff's doctors validated the plaintiff's decision and was unwilling to attempt to talk him into the procedure as the "dangers were real". The court held that because the plaintiff had followed other recommendations from his treating physicians, and because there were serious risks to this procedure, his refusal was reasonable.

An insured who persists in following one physician's recommendations without any improvement in his or her condition, and against the advice of other physicians who recommend different forms of treatment, may be held to be acting unreasonably and thus no longer mitigating his or her losses: *Byron v. Larson*, 2003 ABQB 253, at paras. 126-135.

An insured who refuses on grounds of expense or inconvenience to follow a prescribed course of rehabilitation that would likely be beneficial may not be acting reasonably: *Fulton v. Manufacturers Life Ins. Co.*, [1990] ILR 1-2620 (N.S.Co.Ct.). Similarly, in *Conte v. Canada Life Assurance Co.*, 2005 CanLII 28545 (ONSC), the Court stated in *obiter* that there was no evidence that the insured's failure to follow a recommended course of physiotherapy had been caused by impecuniosity; however, the Court did not need to determine whether the insured had breached the policy's rehabilitation clause because it concluded that the insured had not proven she was disabled at all.

III. TERMINATING BENEFITS

The insurer has an obligation to behave with the utmost good faith when terminating disability benefits. As presented above, the courts are very aware of the vulnerability of disabled insureds and expect that the insureds consider this reality when making decisions regarding benefits. Terminating benefits without legitimate medical evidence to support such a decision may expose insurers to claims for mental distress or even punitive damages.

Any decision to restrict or terminate benefits must be made after appropriate monitoring and investigation, likely by a physician capable of evaluating whether the insured complied with the prescribed rehabilitation treatment, as was done with the independent medical examination in *Sander*.

An insurer likely cannot terminate benefits or plead a failure to mitigate based on an alleged failure to follow a course of rehabilitation if the does not first offer to provide that rehabilitation: *Wright v. National Life Asssurance Co. of Canada* (1987), 25 CCLI 1 (Ont.H.C.); *Gerber v. Telus Corp.*, 2003 ABQB 453, at para. 82.

An insurer who terminates benefits without reasonable grounds can be exposed to damages for bad faith. For example, in *Fowler v. Maritime Life Ins. Co.* (2002), 217 DLR

(4th) 473 (Nfld.S.C.), the insurer terminated benefits for an insured, whom it had previously accepted as disabled, before the insurer received any report from the physician the insurer had retained to evaluate the insured's state of disability. The Court emphasized the "peace of mind" nature of disability insurance contracts and held that the insurer had acted in bad faith. Similarly, an insured who proved mental distress as a result of the bad faith termination of benefits was awarded damages in *Warrington v. Great-West Life Assurance* (1996), 39 CCLI (2d) 116 (BCCA).

Insurers must also consider carefully over what period or from what date they can restrict or terminate benefits. In *Naidu v. Mann*, 2007 BCSC 1313 (CanLII) ("*Naidu*") the plaintiff was unwilling to go through the surgery for thoracic outlet syndrome ("TOS") and the court reduced her damages from the moment that they deemed she should have reasonably undergone the surgery. Similarly, in *Sander* the insurance company terminated benefits only after accounting for the period that would have been required for the insured to book, undergo and recover from the surgery.

Although decided in the workers compensation context, *Decision No.: 2004-533*, 2004 CanLII 70444 (AB WCAC), from the Appeals Commission of Alberta Workers' Compensation ("Appeals Commission"), allowed for a specific carve-out period. In this case the plaintiff did not attend prescribed rehabilitation treatments and did not inform his insurer or his doctor the reason for his non-attendance. The Appeal Commission upheld the Decision Review Body's decision to carve out two separate months when the plaintiff did not attend his rehabilitation sessions and thereby failed to comply with his insurance policy's rehabilitation clause. Although this decision was made by a statutory appellate body and is not effectively precedent for common law courts, it illustrates a practical and flexible approach to the assessment of an insured's compliance with recommended rehabilitation.