Chapter 16

MAKING ALLOWANCES

I. Accommodating Mental Illness and Addictions at Work: Balancing Safety, Human Rights, Performance, and Best Medical Care

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Overview

A growing epidemic surfacing in the North American workplace is becoming overwhelmingly costly in terms of disability, health care, and human suffering. Undiagnosed emotional problems often described as "stress," psychiatric disorders, and addictive disorders cause attendance, behavioural, and safety problems in the workplace that often result in discipline and labour relations conflict. This paper describes an approach—from the perspective of an occupational mental health and addictions consultant—that will often result in effective resolution of labour relations disputes arising from these common problems. I will review some of the more common conditions, outlining the essential steps between the appearance of a problem at work through diagnostic assessment and treatment to safe, sustainable return to work. This approach, while balancing the rights, needs, and liabilities of the various parties, should result in a win-win outcome: the employee will receive the best chance of achieving improved health and continued employment, while the employer may expect improved workplace safety and worker performance. Under this approach, using a motivational technique called contingency management, the employer bears the responsibility of maintaining a safe workplace, while accommodating the worker with the medical condition, while the employee remains responsible for adhering to a

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comprehensive treatment plan based upon his/her specific diagnoses and identified problems. The judge, arbitration panel, or Human Rights Tribunal will often be in a position to ensure that the necessary elements are in place that will not only resolve a dispute, but will also result in what is sometimes an otherwise unattainable outcome: saved lives and healed families.

How Big Is the Problem?

Researchers have identified mental health claims as the most rapidly growing category of disability claims in Canada.[2] Statistics Canada reported in 2003 that 20 percent of employed Canadians experience a stress-related illness every year. One in 10 working Canadians has a diagnosable mental illness.[3] Ten percent of American workers will experience a substance use disorder.[4] People with other mental health disorders are more than twice as likely to suffer from a substance use disorder.[5] Substance use disorders are known to mimic most psychiatric diagnoses (depression, anxiety, stress-related conditions, bipolar disorder, or psychosis).

Determinants of Workplace Mental Health

It is important to distinguish between the achievement of optimal health and the treatment of (and workplace accommodation of) medical or mental disorders. This presentation is focused almost entirely on the effective management of employed people who already have a condition severe enough to interfere with their attendance, performance, behaviour, or safety at work. On the other hand, the most cost-effective approach to this problem in the future—just as it must be in medical care in general—will

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[2]M. WILSON, R. JOFFE, & B. WILKERSON, THE UNHERALDED BUSINESS CRISIS IN CANADA: DEPRESSION AT WORK. AN INFORMATION PAPER FOR BUSINESS, INCORPORATING 12 STEPS TO A BUSINESS PLAN TO DEFEAT DEPRESSION (Global Business and Economic Roundtable on Addiction and Mental Health 2002), *available at* http://www.mentalhealthroundtable.ca/aug_round_pdfs/Roundtable%20report_Jul20.pdf.

[3]C.S. Dewa, N. Chau, & S.W. Dermer, *Factors Associated With Short-Term Disability Episodes,* J. OCCUP. & ENVTL. MED. 51(12):1394–1402 (2009).

[4]J.D. Schulden, Y.F. Thomas, & W.M. Compton, *Substance Abuse in the United States: Findings From Recent Epidemiologic Studies,* CURRENT PSYCHIATRY REP. 11(5): 353–59 (Oct. 2009), *available at* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3144502/.

[5]WORLD HEALTH ORGANIZATION, NEUROSCIENCE OF PSYCHOACTIVE SUBSTANCE USE AND DEPENDENCE: SUMMARY (F.J. Vaccarino & V.S. Rotzinger eds., 2004), *available at* http://www.who.int/substance_abuse/publications/en/Neuroscience.pdf?ua.

be to focus on those factors proven to improve happiness, health, and function.

In order to remain psychologically and medically healthy, human beings have essential needs, including safety, security, belonging, social justice, self-worth, self-esteem, self efficacy, accomplishment, and autonomy.[6]

Researchers have gathered the evidence to clearly identify a group of factors or determinants that definitely affect the mental health of people in their working environment. These include[7]

(1) a supportive workplace: employer values, cares about, recognizes and rewards employees;
(2) a workplace culture of trust, honesty, fairness, civility and respect;
(3) clear, consistent leadership;
(4) "psychological job fit": employee competencies match their jobs;
(5) opportunities for employee growth and development;
(6) involvement and influence: employees are informed of plans, included in the process;
(7) workload management: employees have some control over workload—reasonable chance of successfully completing expected roles;
(8) recognition of importance of work-life balance; and
(9) a workplace that is psychologically safe (from harassment and threats).

In January 2013, a National Standard for Workplace Mental Health in Canada was released. This document outlines a voluntary detailed step-by-step process by which employers of all sizes might develop, implement, and sustain their own comprehensive programs of prevention of mental health problems and promotion of optimal workplace mental health.

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[6]National Standards of Canada, Psychological Health and Safety in the Workplace—Prevention, Promotion, and Guidance to Staged Implementation (2013), *available at* http://www.csagroup.org/documents/codes-and-standards/publications/CAN_CSA-Z1003-13_BNQ_9700-803_2013_EN.pdf.

[7]J. Samra, *Guarding Minds @ Work*, http://www.guardingmindsatwork.ca.

Common Mental Disorders that Impact the Workplace

These include:

- anxiety disorders, such as generalized anxiety disorder, panic disorder, phobias, obsessive compulsive disorders, acute stress disorder, and chronic post-traumatic stress disorder;
- mood disorders, such as major depressive disorder, bipolar disorder;
- thought disorders, such as psychotic disorders;
- complex pain disorders;
- sleep disorders; and
- addictive disorders, including substance use disorders, gambling disorder.

It is very important to note that addictive disorders, especially the various substance use disorders, are able to mimic all of the symptoms of the disorders preceding them on this list.

"Stress"

Confusion over this term is a perennial problem for disability management professionals. In 1936, Hans Selye defined "stress" as the "non-specific response of the body to any demand for change."[8] Stress is not a bad thing. It is essential to health and results in healing, growth, improvement, and survival from a wide variety of pathogens and other threats to life. People complaining of chronic stress are often simply being given the message in the form of unpleasant negative emotional symptoms to make some changes in how they are living their lives. Although chronic, unrelieved stress can and, often does, play an etiological role in the development of many medical and psychiatric disorders, stress is usually not the correct diagnosis. There are two types of psychiatric disorders involving significant stress severe enough to cause demonstrable alteration in neurobiology of the brain: (1) acute stress disorder, usually a self-limited phenomenon, and (2) post-traumatic stress disorder. Although relatively uncommon, both of these conditions are serious, causing severe distress and requiring some form of treatment. When a worker is so unwell that he or she

[8]H. Seyle, *Stress and Disease,* SCIENCE, Oct. 7, 1955, at 625–31, *available at* http://www.sciencemag.org/content/122/3171/625.short.

cannot attend work, it is possible, but somewhat unlikely, that the accurate diagnosis for the problem would be an acute or chronic stress disorder. Usually, however, when an employee produces a brief note, often written by the family doctor on a prescription blank, giving stress as the medical explanation for absence, that is not the real diagnosis and the solution lies in something other than stress leave. It could be an undiagnosed psychiatric disorder, such as anxiety or depression, or a substance use disorder, or sometimes there is a workplace in which there is lack of support, conflict, or impending disciplinary problem, i.e., a labour relations problem.

Addiction

Of the 10 percent of the adult population suffering from substance use disorders, it has been estimated that over 70 percent of those people are currently attending work.[9] Most people with substance use disorders are indistinguishable from their peers most of the time. Bradshaw[10] defined addiction as "a pathological relationship with a mood-altering activity with life-damaging consequences." The American Society of Addiction Medicine describes addiction as:

> A primary, chronic disease of brain reward, motivation, memory, and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social, and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviours. Addiction is characterized by inability to consistently abstain, impairment in behavioural control, craving, diminished recognition of significant problems with one's behaviours and interpersonal relationships, and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death.[11]

The *Diagnostic and Statistical Manual of Mental Disorders,* Fifth Edition (also known as *DSM-5*)[12] has recently refined the diagnostic

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[9]Department of Health & Human Services, Substance Abuse &Mental Health Services Administration, Office of Applied Studies, Results From the 2007 National Survey on Drug Use and Health: National Findings (undated), http://samhsa.gov/data/NSDUH/2k7nsduh/2k7Results.htm#2.10.

[10]http://www.johnbradshaw.com.

[11]http://www.asam.org/advocacy/find-a-policy-statement/view-policy-statement/public-policy-statements/2011/12/15/the-definition-of-addiction.

[12]American Psychiatric Association (2013).

criteria for substance use and addictive disorders. Along the continuum of substance use, extending from complete abstinence, through occasional or recreational use of potentially addictive, mood-altering substances through to end-stage addiction, the terms substance abuse and substance dependence have been merged into the umbrella diagnosis of "substance use disorder." In people receiving prescription drugs capable of causing neuroadaptation with sustained use, signaled by the symptoms of increased tolerance for the drug and withdrawal upon cessation of the drug, these symptoms or indicators have been removed as diagnostic criteria. Craving has been included as a diagnostic indicator and prior legal problems related to substances has been removed as a diagnostic criterion.

From the perspective of a healthcare professional specializing in Addiction Medicine, the key to understanding addiction lies in appreciating that the addicted person is—whether through nature or nurture—unable to adequately comfort himself or herself in times of emotional distress. For that reason, the mood-altering substance or behaviour becomes more and more important in providing relief, reward, or pleasure that would otherwise be denied. Of course, the problem is that, in addiction, the very substance or behaviour providing the sought-after escape or comfort begins to cause escalating problems and even more emotional discomfort. Two other factors combine to create the perfect storm: increasing impairment in effective behavioural control over the addictive behaviour, once it has begun, is combined with unconscious defense mechanisms, such as denial, rationalization, and intellectualization. The addict becomes incapable of appreciating the magnitude of accumulating negative consequences.

The reason for my pointing out these unique emotional and behavioural features characteristic of persons with addictions is to emphasize the importance of active and firm intervention followed by careful, comprehensive, long-term treatment. If we simply prevent the addict from using his or her addictive substances or behaviours, we may have at least temporarily solved one of their problems, while entirely neglecting the bigger issue: how to achieve emotional comfort. Treatment of addiction must be staged, customized for the needs of the patient, and it must be long-term, just as with any other chronic, recurring disorder.

First, the addicted person might require detoxification, sometimes an alarming and even dangerous period of treatment, allowing the drug-altered brain to recover from the effects of the

substance. He or she might benefit temporarily from a carefully prescribed medication to reduce craving, lessen rebound effects of withdrawal, or reduce the risk of early relapse. The next essential step for the person in early abstinence will be to learn and practice new behaviours, refusal skills, and alternative non-chemical coping strategies. This will often occur in the setting of an intensive, multidisciplinary treatment program—either inpatient or outpatient. Patients often need help to identify exactly which missing pieces of their puzzles they will need to work on—such as ways to recognize and handle negative emotions, conflict resolution skills, assertiveness, healthier eating, sleep hygiene, the development of effective interpersonal boundaries, and athletic and exercise activities. Finally, and perhaps of most importance, the recovering person must rejoin the human race, integrating back into family, society, peer support groups, and the workplace. Some of the most important long-term outcome data on large populations of recovering alcoholics has demonstrated that the most reliable single predictor of stable, abstinent, long-term remission is involvement in an addictions recovery mutual support group program, such as Alcoholics Anonymous.[13] Woven through many or most effective programs for the management of addictive disorders are spiritual elements of prayer—meditation combined with principled behaviours: "If you want to feel good, you gotta do good."

Hitting Bottom: The Cost/Benefit Analysis

What does it take to arrive at that magic moment when the addict (or the overweight executive with mild chest discomfort on exertion or the obese person with type 2 diabetes) admits he or she is in trouble and reaches out to begin the recovery process? All of us continue doing the things we do based upon our ongoing cost-benefit analysis of the situation. As long as our tally tells us the benefits of our behaviours (no matter how much nagging we are getting from concerned others) outweigh the perceived consequences, we will continue doing what we've been doing. Although more prominent in addictions—but certainly not unique to addicts—those sneaky defense mechanisms we use to justify our misbehaviour, are, by definition, unconscious: we are unable to accurately appreciate the magnitude of the negative

[13] G.E. Vaillant, Natural History of Alcoholism revisited (1995).

consequences. Only when the denying, rationalizing, intellectualizing addict (obese person, impending heart-attack victim) experiences that temporary window of clarity, most often in the form of a painful negative consequence, will he or she take the necessary steps to get help. Enabling (killing them with kindness) is a term embraced by the addiction community referring to acts of well-meaning friends, family, employers, and helping agencies that relieve the unpleasant effects of those negative consequences. For some people, a single blackout, a drinking driving offence, or social embarrassment while intoxicated is enough to trigger the change. Although some never get the message and die of their progressive disease, there are some who only got clean and sober after the warnings, discipline, and last chances were over and they experienced termination. Enabling can take many forms—concealment, endless warnings, inaccurate medical diagnoses on insurance claims, or switching the active alcoholic worker from a safety sensitive position to a desk job, rather than insisting upon proper treatment of the disease.

Signs of Problems at Work

Whether the problem is due to unresolved stress, depression, anxiety disorder, chronic pain, or many gradually worsening medical conditions, there are signs and symptoms that a vigilant manager should notice:

- deterioration in attendance, perhaps with a characteristic pattern;
- sudden change in personal appearance;
- uncharacteristic behaviours;
- increasing interpersonal conflict;
- possible impairment: unsteady gait, slurring, poor coordination, slowed response; or
- repeat disability claims.

These should result in a private and respectful conversation between the manager and employee.

When to Ask for an Independent Medical Evaluation

Privacy and confidentiality statutes limit the type of information the employer may demand and regulated health professionals

may provide. Although the employer must be able to determine whether or not workers are fit to safely perform their jobs, they are not permitted to demand diagnostic or treatment details. For this reason, employers must rely on communications on behalf of the employee/patient from attending physicians. The medical information must be sufficient for both the disability insurer and employer, so that important decisions may be made with respect to

- fitness to work;
- general nature of the disability;
- predicted duration of disability;
- whether treatment has been prescribed and is being adhered to;
- recommendations with respect to workplace restrictions and accommodations;
- special recommendations, such as the need and specifics of medical monitoring; and
- prognosis.

When there is insufficient information or when the medical explanation seems inadequate to explain the situation, the employer or insurer might request the opinion of an independent medical evaluator or medical specialist.

The Occupational Diagnostic Evaluation for Mental Disorders/Addiction

This examination must be performed by a medical professional or team with recognized expertise (addiction, pain, psychiatric disorders, medical problems) with no prior, present, or future therapeutic relationship with the examined person.

Specific Questions to Be Answered

- Is this person fit to safely perform the job?
- Is there a medical/psychiatric/addictive disorder requiring accommodation?
- Is the problematic attendance or behaviour related to the disorder?
- Has appropriate diagnosis and treatment been provided to the employee?

- Has the examinee made reasonable attempts to adhere to recommended treatment?
- Are there recommended accommodations and restrictions for safe, sustainable return to work?
- What is the predicted duration of complete/partial disability?
- What is the prognosis?

Components of a Comprehensive Biopsychosocial Evaluation

- Informed voluntary consent
- Thorough chronological medical history
- Psychiatric history
- Psychosocial history
- Pain history
- Medication review, including electronic records if available
- Physical examination
- Appropriate laboratory investigations, including general blood tests, urine tests for common substances, other medical investigations based on results of history, and physical exam
- Self-administered questionnaires (cognitive, depression, anxiety, gambling, pain, alcohol, and other substance use)
- Review of collateral documentation (medical, workplace)
- Collateral interviews: workplace representative, medical practitioners, other treatment personnel, family, support-group person
- Diagnostic formulation
- Staged treatment plan
- Longer term medical monitoring recommendations
- Return-to-work recommendations, including accommodations and restrictions—specific workplace situations to be avoided (e.g., exposure to drugs/alcohol).

Treatment of Addictions
(With and Without Psychiatric/Pain Comorbidity)

When psychiatric symptoms (depression, anxiety, panic, psychosis) or chronic pain with chronic opioid treatment are present with active substance use disorder:

1. Active addiction is very often accompanied by symptoms that might be mistaken for psychiatric disorders but are caused by the substance use disorder. Although it might be necessary to initiate treatment that includes therapy for a

possible concurrent psychiatric disorder, these secondary psychiatric symptoms will gradually subside with stable remission of the addiction.

2. Both addictive disorders and psychiatric disorders are "primary" conditions—it is a mistake to assume that treating one as the "underlying" problem will cause the other to go away—both conditions must be treated concurrently.
3. In a patient with substance dependence, it is impossible to treat a concurrent psychiatric disorder or a pain disorder until or unless the substance use disorder is also being treated.
4. Treatment must be staged:
    a. Detoxification/stabilization, sometimes requiring active medical, psychiatric, pharmacologic care
    b. Early intensive treatment either inpatient or outpatient, depending upon severity and stability of patient, to develop
        i. Psychoeducation about the nature of the disorder(s)
        ii. Refusal skills
        iii. Self-examination to determine absent coping skills (missing pieces of the puzzle)
        iv. Introduction and early practice of non-chemical coping skills
        v. Psychotherapeutic and/or pharmacologic treatment of serious comorbidity or emotional trauma
        vi. Introduction to community-based recovery resources: counseling, mutual support group programs.
    c. Post-treatment or "aftercare" is by far the most important component of treatment, and it includes
        i. Active involvement in mutual support group program
        ii. Accountability to family, sponsor, workplace, medical monitor
        iii. Medical/medication management of all diagnoses
        iv. Regular aerobic exercise
        v. Nutritional program
        vi. Sleep hygiene
        vii. Return to work process

viii. Daily spiritual activity (e.g., meditation, prayer, acts of kindness/volunteer work, etc.).

During the first two years of early recovery, persons with a history of substance use disorder—especially those who had been troubled by symptoms of mood disorder, anxiety, mood swings, personality disorder, and pain during active addiction—will oscillate wildly as they slowly learn to apply their new skills to cope with life's discomforts. Unfortunately, during this period, they sometimes receive incorrect diagnoses and treatments for conditions mistakenly diagnosed as bipolar II disorder or attention deficit disorder, but if they are given support and encouragement, especially from those ahead of them on the journey of recovery, these troubling symptoms will usually gradually settle and disappear.

Contingency Management: Medical Monitoring

Substance use disorders are chronic, progressive, and potentially fatal conditions that do not usually become apparent at work until a relatively late stage. The early responders or "high bottoms" have made the necessary changes or sought help long before the problem began to impact their attendance, performance, behaviours, or safety at work. In spite of relatively late stage intervention, there is a recognized group of substance dependent workers, who have been mandated to receive treatment, that routinely achieve rates of recovery (stable, abstinent, long-term remission) of 74 to 90 percent.[14] The fact that these people are physicians (similar results have been achieved with airline pilots), with their self-discipline and goal-oriented behaviours, might account for part of their remarkable success; however, there is likely another explanation. Contingency management is a motivational technique that has been used successfully to initiate, motivate, and sustain behavioural change in homeless populations of persons with addictions and mental illnesses, in apprehended drinking drivers given the alternative of diversion, and in drug courts. What is required is a motivator or reward for certain behaviours (full compliance with a long-term treatment plan and naturally occurring consequences for non-adherence to a relapse prevention agreement). It turns out that substance dependent people enrolled in mandatory

[14]K.H. Berge, M.D. Seppala, & A.M. Schipper, *Chemical Dependency in the Physician,* MAYO CLIN. PROC. 84(7):625–63 (July 2009).

medically monitored relapse-prevention programs have by far the greatest rates of successful recovery.

Medical Monitoring

It is important not to confuse medical monitoring with simple random drug testing programs used in a variety of safety sensitive industries, especially in the United States.

People with addictions, especially those with psychiatric, medical, and pain comorbidity, are complex. Addictions and many serious co-occurring mental health disorders are chronic conditions—meaning these conditions are quite likely to relapse in the future. If employees with these mental health disorders work in safety-sensitive or highly responsible positions, or if they have reached the point that the employer has difficulty accommodating them because of their illness, the only safe way to return them to work is to establish a mechanism to ensure they continue to follow their medical and psychiatric treatment plans. Medical monitoring is an extension of the occupational addictions/psychiatric evaluator's treatment plan. All components of long-term treatment and relapse prevention are included in a relapse prevention agreement, signed by the participant at enrollment. The relapse prevention agreement—a confidential medical document (not to be confused with the return-to-work agreement between the employer and employee/union)—contains details about required medical treatments, psychiatric treatments, counseling, mutual support group activities, communication between all treatment providers, review of all prescribed and non-prescribed medications, randomly scheduled biological testing, and compliance reporting arrangements. Duration of agreements vary, depending upon the severity of the disorder and the level of responsibility of the participant, starting at two years and extending up to 10 years or, in some cases, as long as the at-risk participant holds a certain position. Compliance represents a continuum—from reluctant-resistant compliance with minor issues of non-adherence, through missed appointments all the way to concealed full relapse. Reporting to the employer, insurer, or regulatory body is on a regular schedule, but in the event of critical non-compliance, such as a relapse in a safety sensitive worker, immediate reporting is essential. Careful medical oversight of the monitoring and biological testing process is an important part of the process in order to assist the oversight body or employer in making the best decisions.

High-quality medical monitoring is not cheap, and although it is probably the most important factor to achieve the highest rates of recovery, it is not considered "treatment"—there can be no therapeutic relationship between monitoring personnel and participant—so it is not usually a medically insured service.

Conclusions

Addictions, often complicated by mental health problems and pain disorders, are remarkably common, affecting over 10 percent of the workforce. These chronic, progressive, and potentially fatal conditions are remarkably responsive to treatment, provided the treatment is based upon a thorough and accurate diagnostic process and the treatment plan is followed for enough time to achieve stable sustainable remission. Although addictions and associated mental health conditions do not come to the attention of the employer until they have become serious problems, workplace intervention and contingency-based treatment results in extremely high rates of safe, stable, and sustainable return to work, as well as return to health and happiness for the sufferer. Employers, unions, and those assigned Solomon-like duties of resolving disciplinary issues between these parties may play a vital role in early identification, intervention, proper assessment, treatment, relapse prevention, and return to work for these employees.

II. Panel Discussion

Moderator: **Stan Lanyon,** National Academy of Arbitrators, New Westminster, BC

Panelists: **Dr. Ray Baker,** University of British Columbia, South Surrey, BC

Justice John Steeves, Supreme Court of British Columbia, Vancouver, BC

Susan L. Stewart, National Academy of Arbitrators, Toronto, ON

Stan Lanyon: We're at the point of adjournment. So, I don't know if there are any particular questions?

Andrew Strongin: What do you do when you have an employee who denies a problem, and an employer who believes there is

a problem? The employer sends him to a psychiatrist who says there's a problem. The employee finds his own doctor who says there's no problem at all. Someone's got to decide.

Dr. Ray Baker: The question is when the employee denies there being a problem, the Independent Medical Examination (IME) was done by a psychiatric person who said, "Yes, there is a psychiatric or addictive, or whatever, disorder." The employee had found an expert who said, "No, there isn't a problem here." How do you resolve that as being the arbitrator, mediator, or judge? My recommendation, then, would be to have both parties agree on a final medical expert who would provide the required opinion. That's the way we do it with worker's compensation cases.

Where there'll be a chosen final evaluative, whether a team or an individual, that both parties agree to, and they agree to go with that medical opinion.

Susan Stewart: If I can just respond to that, briefly. I suppose from an adjudicative perspective what you could do is what Stan Lanyon did in the BC case. He ordered an IME, which is essentially the result of what Dr. Baker has indicated would take place, in his experience.

The other thing, of course, is that as an adjudicator we just have the evidence. You're often faced with contradictory evidence, and so there are rules around adjudicating evidence. Right? You look at the logic of the analysis and you evaluate it.

John, do you have anything further on that?

Justice John Steeves: I think you need a hammer, and the hammer is adjudication. And you just put a stop to the to-ing and fro-ing and say, all right, if it can't be you, then it has to be somebody else and let's get down to it. I don't think you do the kind of example you've described. It doesn't do anybody any favors. It's expensive. It's confusing and we can only wonder what effect it has on the grievor, assuming the grievor has real psychological problems.

Larry Steinberg: I'd like to ask Dr. Baker if he could comment on the role of the family doctor for some of these situations, very specifically the fact that the relationship between the employee and the family doctor can be quite deep, quite strong. In many cases, I don't want to paint with a wide brush, but I find that the family doctor sometimes tends to be an advocate for that individual.

Dr. Ray Baker: The issue is what is the role of the family physician in these cases? You made the statement that the family physician sometimes comes across as an advocate. For very good reason, they are. That's part of their job; they're the advocate. On

the other hand, they know this person better than any of us hired, and no matter how well trained we are, they have a long-term relationship. So, perhaps the majority of these cases do get resolved with the expertise of the family doctor. But sometimes they can be a barrier, and that is where all these other processes and the other experts come in.

I'm way over my head when it comes to putting weight on the evidence, but I think that has to be factored in—that the insight of a good family physician is tremendous and it's very, very illuminating and important. But, we do have to remember that they don't have an unbiased relationship here. They have a job and their job is to be advocate. That's where the "I" of the independent comes in is that this person, ideally the independent evaluator doesn't have—isn't on a side and they can give you a more unbiased response.

I love the idea of the conjoint expert to take some of that subject of non-objective relationship stuff out of the picture. I don't want to diminish the role of the family doctor. Having been a family doctor for many years, you get used to being—it's like just the housewife, just the family doctor. You get demeaned all the time. So, I think he or she has to be respected, but you have to put weight on the value of the evidence. I think you people are doing that all the time with evidence.

Stan Lanyon: Let's bring it to an end, so one more question.

Audience Member: I'm from the United States. I wonder how you would deal with a zero tolerance kind of policy that you have here and our employers have here in the United States towards drugs and alcohol in some cases? And also the effect of medical marijuana.

Dr. Ray Baker: I'll do the medical marijuana part. So the issue of zero tolerance and not wanting to accommodate people with addictions, I will leave to my legal colleagues here. Medical marijuana is a misnomer. Medical marijuana is… there are better treatments. Medical marijuana cannot stand the test of any other prescribed drug. So, with employed personnel, especially if they're safety-sensitive, but if they have problems with attendance, performance, and behavior, and they choose to use that particular drug, medical marijuana is a misnomer. There's no place for it and it's just simply not acceptable medically. It's just bogus. From an occupational perspective, it's bogus. It's really political ideology. It's not medical at all.

Justice John Steeves: From a legal point of view, zero tolerance is clearly the hammer. But, in most jurisdictions in Canada, arbitrators have what we call substitutional jurisdiction. It's described as a just cause standard. So, an employer can say zero tolerance. One, you're caught with one offense and you're fired. That's fine. But when it comes before the arbitrator, the arbitrator considers it under a just cause standard and, in comparison with other cases, and so on. So, at the end of the day, just a zero tolerance standard will not be binding on the arbitrator in this jurisdiction anyway.

Susan Stewart: Just one further comment on that in terms of zero tolerance. If there is a medical disability and drug use is an aspect of that, if there's an addiction issue, there's a duty to accommodate. So, zero tolerance is a problem.

Stan Lanyon: Please give a round of applause to our panelists. Thank you.