IN THE MATTER OF AN ARBITRATION

BETWEEN:

RIO TINTO ALCAN INC.
(the “Employer” or “RTA”)

AND:

UNIFOR, LOCAL 2301
(the “Union”)

(Medical Information grievance)

ARBITRATOR:	Michael Fleming
COUNSEL:	Kevin O’Neill, Q.C. for the Employer Peter Shklanka, for the Union
DATE OF HEARING:	May 31, June 1, 2, 2017
DATE OF CLOSE OF SUBMISSIONS:	August 21, 2017
DATE OF AWARD:	November 17, 2017

Nature of Issue

The Union filed a policy grievance and three individual grievances alleging that the Employer had breached Article 37.10 of the Collective Agreement by requiring employees in receipt of Kitimat Works Disability Indemnity Plan ("DIP") benefits to undergo a consultation and examination by an RTA physician. The grievances also alleged that the Employer overstepped any right it had under the Collective Agreement to collect medical information through the consultations and examinations by the RTA physician.

The Union asserts that the Employer's actions are unreasonable and constitute arbitrary intrusions on employees' dignity and privacy.

The parties have agreed that the names of the individual grievors should be anonymized.

Background

The Employer operates an aluminum smelter in Kitimat B.C. The Union represents employees in the Employer's smelting operations. There is no real dispute that the smelter is a safety sensitive workplace.

The parties have a very long-standing collective bargaining relationship.

The Employer provides medical and health services to its employees through its Occupational Health Department (the "OHD"), which has operated for more than 30 years.

Article 37 of the Collective Agreement provides for the DIP. The parties have agreed that the Employer will provide wage loss protection to eligible employees who are absent from work due to non-work related illness or injury.

Under Article 37, an employee is considered disabled when, in the opinion of the OHD in consultation with an employee's treating physician, the employee is unable to perform their regular job duties or other meaningful jobs assigned to them, as a result of a non-work related illness or injury (Article 37. 01 (c)).

Eligibility for DIP benefits requires that an employee visit a physician within five days of the start of a disability. The employee is also required to return a completed Physician's Report (supplied by the Employer) as well as the completed DIP application form to the OHD (Article 37.02).

The OHD may require an employee to provide further medical evidence of disability (Article 37.03 (a) (i)).

Article 37.09 (a) provides that the OHD will determine if an employee continues to be disabled, in consultation with the employee's treating physician.

Article 37.10 (a) reads as follows:

> *(a) The Company reserves the right to have the employee examined by a physician of its choice. The decision of the Company's Occupational Health Department (in*

> *consultation with your attending physician) regarding whether an employee is disabled is final.*

The RTA policies relating to the OHD characterize one of its primary purposes as being to further health and safety in the workplace and to ensure that employees are capable of performing their job duties.

The OHD is made up of a case administrator, two occupational health registered nurses, two physicians and one physician assistant (since 2016).

Historically, OHD physicians were on site on a full time basis. However, within the last nine years that role has changed to a consultancy. In that regard, the OHD physician travels to Kitimat for four days, two times each month.

The OHD physicians have, for several decades, conducted examinations of employees where the OHD physician has determined that to be an appropriate course of action. The OHD physician has been the final word regarding whether an employee is fit to return to work.

The longest serving OHD physicians are Dr. Lori Galbraith and Dr. Vern Davis, both of whom are among the small number of physicians in Canada specializing in occupational health medicine. Dr. Galbraith, who testified at the hearing, was previously the Chief Medical Officer ("CMO") with the OHD. Dr. Galbraith has specialized expertise in occupational health medicine including a fellowship through the Canadian Board of Occupational Medicine.

The OHD has operated in the same manner for many years. The Health Evaluation Program Policy (2003) stated in part that fitness for work evaluations (the "Evaluation") conducted by the OHD physicians, in conjunction with the employee's treating physician, will be used to determine an employee's fitness to work.

That document expressly provided that the Evaluation would be done by the CMO who would then forward limited information such as restrictions, but not diagnostic or confidential medical information, to the Return to Work Co-ordinator at RTA, who will in turn communicate that information to management and other RTA staff on a need to know basis.

The Health Management Program Policy (2004) provided in part that OHD physicians are to:

- Serve as the primary liaison between management, health care providers, worker's compensation carriers and injured or ill employees;
- Determine the scope of and conduct medical examinations including pre-placement, periodic, return to work, fitness for work and departure evaluations of health that are pertinent to job tasks and exposures to chemical, physical, psychological, biological and ergonomic factors;
- Interpret medical findings and advise RTA management on occupational health issues;

- Serve as a medical resource liaison between providers, specialists, the injured or ill employee's treating physician, workers' compensation carriers and RTA management;

- Take an active role in the case management of injured or ill employees from the initial treatment through rehabilitation, in collaboration with the Work Accommodation Co-ordinator.

There is no real dispute that the OHD physicians assess DIP claims on their face; conduct examinations and consultations of employees; liaise with RTA managers and human resources staff in respect to health and safety matters and DIP claims, fitness to work and accommodation issues; liaise with the employee's treating physician and conduct examinations and consultations of employees during DIP claims.

The role of the OHD Occupational Nurse is characterized in part as being responsible to:

- Co-ordinate the scheduling of employees for medical examinations and other health service activities;

- Under the supervision of the OHD physician, to conduct periodic and other health assessments;

- Provide counselling to employees regarding health risks in the workplace;

- Be familiar with site processes;

- Act as liaison between the site and other health professionals.

- Assist employees to access the Employee and Family Assistance Program.

The roles described in those documents generally reflect both the historical and current practices of the OHD medical staff.

As contemplated under Article 37.02 of the Collective Agreement, the DIP process is generally initiated where an injured or ill employee attends at their physician's office for an assessment. That physician completes the Physician's Report which includes a diagnosis, an assessment of the employee's ability to return to work and identifies any medical restrictions. That form also provides a space for the employee to give their consent for the information in the report to be released to the OHD.

A DIP application form which is provided by RTA, is attached to the Physician's Report and is completed by the employee and returned to the OHD. Once those documents have been provided to the OHD, an OHD case administrator reviews them to determine if the forms have been correctly completed or if any information appears to be missing. The forms are expected to

provide a clear diagnosis, identify medical restrictions, describe a treatment plan and provide the anticipated date of a return to work.

If the form contains sufficient information, the information is entered into an electronic data base system for DIP known as Medgate. A report highlighting any medical restrictions (but without a diagnosis) and the date of an anticipated return to work is then generated.

In those cases where the Physician's Report is incomplete, an OHD case administrator or an OHD nurse may contact the employee's treating physician to obtain the missing information.

The Physician's Report is also reviewed by an OHD nurse to determine if any follow-up may be necessary in the context of the employee's ability to perform work or whether any referrals (i.e. to the Family Assistance Program for example) may be appropriate.

In general terms, the employee's treating physician provides information relating to the employee's medical restrictions and treatment plan and OHD determines how those restrictions may be accommodated.

The uncontroverted evidence is that most DIP claims are approved following a review of the Physician's Report by an OHD nurse. Those cases where follow-up is found to be necessary are typically cases where the medical restrictions identified by a treating physician may require some form of accommodation.

Where an examination or consultation of an employee by the OHD physician is found to be necessary, any follow-up examinations or visits with the OHD physician are scheduled on a case by case basis.

The Evidence

Operation and Practices of OHD

Dr. Galbraith

Dr. Galbraith is one of the two occupational health physicians (along with Dr. Davis) in the OHD and has specialized in occupational health medicine since the late 1990s.

Dr. Galbraith was the full-time CMO between 2006 and 2009 and has been on contract on a part-time basis in essentially the same role since 2010. As noted, in that capacity she travels to Kitimat twice each month for about three to four days each trip.

Dr. Galbraith testified that in 2015-2016, the focus of her work at the smelter was on assessing the medical restrictions of employees' fitness to return to work in the context of the modernization of the smelter and resulting changes to the workplace and job duties which were occurring in that time-frame.

The policy and individual grievances were filed in March and April of 2016.

Dr. Galbraith said that her role as the OHD physician involves referrals of employees to external resources and to liaise with medical specialists and other medical professionals. In that regard, Dr. Galbraith would see an employee who had been referred to her to assess and determine if a

more specialized assessment may be necessary. If she concludes one is useful or helpful, with the employee's consent, she would make a referral to a specialist, usually as an Independent Medical Evaluation ("IME").

Dr. Galbraith said that on completion of the IME, she typically receives the IME report. She would then obtain the employee's consent and provides the report to the employee's treating physician.

Dr. Galbraith testified that she does not become involved in most DIP cases. She said her involvement is usually triggered through the OHD nurse or where an employee requests a meeting, or through a referral by the employee's treating physician or, from time to time, where an issue has arisen in the workplace raising concerns for RTA management regarding the employee's functioning in the workplace.

Dr. Galbraith also said that she conducts follow-up visits with employees from time to time where she has referred an employee to a specialist. By way of example, she said that where she refers an employee for magnetic resonance imaging (MRI), she is professionally obliged to follow-up that referral with the employee.

Dr. Galbraith said that she also may have follow-up visits where an employee is returning to work, particularly a graduated return to work, in order to assess the employee's progress or ability to actually perform their job duties.

Dr. Galbraith testified that, from time to time, an employee is referred to her through an RTA manager who may have questions regarding the reasons for an employee's absence. However, she said that the OHD has no labour relations role or function. Rather, its role is strictly related to medical issues. Dr. Galbraith said that the only information provided by the OHD to RTA managers relates to an employee's fitness to return to work or information necessary to facilitate an accommodation.

She went on to say that the OHD does not provide RTA managers or human resources staff with information regarding an employee's diagnosis or treatment, or any other confidential medical information. She also noted that the OHD operates on an "arms-length" basis from RTA.

Dr. Galbraith agreed that an RTA manager could request that an employee be seen by her. However, she said that, consistent with the arms-length relationship, the manager would not receive any medical information that might be disclosed through such an appointment.

Dr. Galbraith explained that her practice is that, when she first meets with an employee she asks them if they understand the purpose of the meeting. If they say that they do not, she provides them with an explanation.

Dr. Galbraith explained that her role is not to be the employee's treating physician, going on to say that the OHD is very cautious about protecting the confidentiality of any employee medical information that is provided to the OHD. If the OHD concludes that more medical information is necessary, the OHD asks for the employee's consent for the release of specific information related to a specific purpose.

Dr. Galbraith said that medical information possessed by the OHD is treated, in terms of confidentiality, in the same way it would be by a physician in private practice.

Dr. Galbraith testified that she does not make the decision regarding whether DIP benefits should be terminated.

Dr. Galbraith explained that her usual practice is to not contact an employee's treating physician unless she is first contacted by them. She said that her role with an employee is to assess their medical restrictions and any ongoing condition that may impact the employee's return to work, but her role does not include treatment of the employee.

Dr. Galbraith said that she could not recall ever being advised of any obligation under the Collective Agreement requiring the OHD to consult with an employee's treating physician. She said that had never been previously raised as an issue with her.

Dr. Galbraith testified that it had not historically been the OHD's general practice to consult with an employee's family physician before determining whether an employee is disabled, going on to say that family physicians in Kitimat are extremely busy often seeing 50 to 60 patients each day and that, in her view, it would be a real burden on the family physicians if the OHD were to contact them in every case.

Amanda Martins

Ms. Martins has been employed as an OHD nurse at RTA since 2014. Ms. Martins received specialized training in occupational health medicine.

She testified that Kitimat is a very small community with very limited access to medical specialists. As a result, the OHD assists employees by expediting referrals to specialists and other medical services. For example, the OHD is often able to have expedited appointments scheduled for tests such as an MRI or drug and alcohol resources in as little as one week.

Many of those referrals are paid for by the Employer.

Ms. Martins said that all the family physicians in Kitimat have the Physician's Report forms. She went on to say that employees are expected to return the completed forms and the DIP application form directly to the OHD. She said that it would be unusual for employees to provide those forms to their supervisor and that the OHD's practice is to discourage RTA supervisors and managers from accepting the forms from employees.

Ms. Martins testified that an injured or ill employee's supervisor does not receive the Medgate form. Rather, they are only provided with a report which contains very limited information. She explained that the employee medical information obtained by the OHD is stored in a locked room in the OHD building, which is not part of the main RTA office building. Only OHD medical staff have access to the medical information which can only be released with the signed consent of an employee.

Ms. Martins noted that the OHD works very closely with the Joint Medical Placement Committee for which there is a specific provision in the Collective Agreement; i.e. 22-LU- #1. That committee is involved in the accommodation of, and ensuring a successful return to work of, ill or injured employees. Ms. Martins explained that OHD staff (currently herself) sit on that committee as a resource to assist the committee in its work.

Ms. Martins said that while the vast majority of DIP claims are approved, approval is not automatic. She went on to say that the OHD staff may schedule an appointment for an employee with the OHD physician where, for example, the Physician's Report does not contain sufficient information to allow the OHD to determine the types of possible accommodations that might be put in place for the employee.

Ms. Martins explained that the OHD's focus is on accommodation related issues. She noted that Physician's Reports may include medical restrictions which appear to be accommodations. For example, a physician may indicate that an employee should have a standing desk. Ms. Martins said that in that case, the OHD would need to know what the employee could actually do. For example, would they be able to sit for 20 minutes and/or stand for 20 minutes.

Ms. Martins testified that the decision to schedule an appointment for an employee with the OHD physician is made on a case by case basis. Factors that go into that decision may include the fact that that employee had agreed to provide specific information relating to a possible accommodation and OHD physicians are familiar with the smelter and available accommodation measures. As well, appointments may also be scheduled to allow the OHD to assist in arranging an expedited referral to a medical specialist.

Ms. Martins explained that where the OHD determines that an appointment with the OHD physician should be made, she typically contacts the employee, introducing herself and explaining the purpose of the call. If she believes it to be appropriate, she will then offer the employee an opportunity to meet with the OHD physician to review their medical status in the context of a possible return to work or accommodation.

Ms. Martins agreed that from time to time, an employee may be referred to OHD by their manager. She said that would usually be the result of a workplace injury or where a manager or supervisor has observed some problems or difficulties experienced by an accommodated employee.

Ms. Martins testified that a referral to an OHD physician might also be made where, for example, the employee's treating physician had suggested an accommodation or the return to work is complicated.

When asked about the kind of circumstances that an employee's treating physician may not be able to fully address, Ms. Martins gave the example of an employee who had suffered seizures but had had their driver's license restored. She said that in those circumstances there may be a question regarding the employee's ability to operate a machine or drive in the plant, which is a safety sensitive workplace. Ms. Martins went on to say that the OHD physicians are specialists in occupational health medicine and have an extensive knowledge of the smelter.

Ms. Martins testified that typically, if the OHD concludes that an employee is not fit to work, the OHD makes a recommendation to that effect, which is typically accepted by RTA managers. She said the decision regarding whether DIP benefits should be suspended or ended is made by RTA management, not the OHD.

Ms. Martins said that the vast majority of DIP claims are accepted without the involvement of RTA management, and agreed that most DIP claims are approved by the OHD on the basis of the information provided by the employee's treating physician.

Ms. Martins noted that during 2015-2016, the focus of the OHD was on assessing the medical restrictions of ill or injured employees in the context of the modernization which occurred in that time-frame and which caused changes to the workplace and job duties in the smelter.

Ms. Martins explained that the employees' treating physicians were involved in that process and the OHD requested that employees have their family physicians re-assess the employees' medical restrictions and provide that information to the OHD.

Dr. Howard Mills

Dr. Mills has been a family physician in private practise in Kitimat for 36 years. In his practice he has a number of RTA employees as patients.

Dr. Mills testified that he worked as an OHD physician for a period of time about 35 years ago. He went on to say that he has a productive, professional relationship with Dr. Galbraith and they have in the past, and continue to, work collaboratively in respect to the accommodation of ill or injured RTA employees.

Dr. Mills agreed that Dr. Galbraith has expertise in occupation health medicine and is very familiar with the smelter. He also said that in his experience, it is not uncommon for Dr. Galbraith to see his patients at the same time he is treating them. He went on to explain that he saw Dr. Galbraith as being a valuable resource in ensuring the safe return to work of ill or injured RTA employees.

He explained that Dr. Galbraith's current practices are the same as those that have been in place for decades.

Individual Grievances

MW

MW has been employed by the Employer for 22 years. She testified that she suffers from severe elbow pain and lupus.

There is no dispute that MW has a chronic medical condition which the Employer has accommodated for some time. She has largely been absent from work since February 9, 2016.

As a result of her medical condition, as part of her treatment, MW visits Dr. Diane Lacaille, a rheumatologist in Vancouver about every six months.

MW saw Dr. Lacaille on March 7, 2016 and Dr. Lacaille wrote a report on the same date addressed to MW's treating physician in Kitimat. In her report, Dr. Lacaille wrote that MW had advised that she had been off work for one month and had noted improvement in her symptoms. Dr. Lacaille expressed the view that while improved, MW's condition was "not completely resolved".

The report went on to outline a treatment plan which included various medications. The report did not comment on or express any opinion regarding whether MW was disabled or in respect to her fitness to return to work.

MW testified that Dr. Lacaille examined her and gave her an injection to ease MW's elbow pain.

On March 15, 2016, MW was seen by her treating physician in Kitimat who completed a Physician's Report on the same day. That report, which indicated that MW was totally disabled with an anticipated return to work date of April 15, 2016, was forwarded to the OHD on March 17, 2016.

MW said that while Dr. Lacaille's report said nothing about MW's return to work; she recalled that Dr. Lacaille told MW in the March 7, 2016 appointment that she should not return to work for a month following the injection administered on March 7, 2016.

MW testified that on March 21, 2016, she was contacted by Ms. Martins who requested a copy of Dr. Lacaille's report. MW said that Ms. Martins also asked MW to attend an appointment with Dr. Galbraith on March 31, 2016. MW went on to say that she did not recall the reason for that appointment being explained to her.

Ms. Martins testified that MW had a number of restrictions on her ability to work which she has had for a number of years. Ms. Martins went on to note that the March 17, 2016 Physician's Report indicated a further absence from work would be required. Ms. Martins explained that the OHD wanted to meet with MW in order to assess whether any accommodation measures could be put in place to facilitate a return to work. The purpose of the appointment with Dr. Galbraith was to make that assessment. Ms. Martins said that when she spoke with MW to arrange the March 31, 2016 appointment, she also asked MW to provide a copy of Dr. Lacaille's March 7, 2016 report to the OHD to assist in the accommodation assessment, which MW agreed to do.

Ms. Martins explained that the information that the OHD was interested in canvassing could not be obtained from MW's treating physician because it related to a possible accommodation at the smelter.

MW acknowledged that she had agreed to have a copy of Dr. Lacaille's report sent to OHD for the March 31, 2016 appointment. She acknowledged that she did not provide the report prior to the appointment or take it with her to the appointment.

MW attended the scheduled appointment with Dr. Galbraith but not bring Dr. Lacaille's report with her.

MW recalled that she told Dr. Galbraith that Dr. Lacaille had advised that MW should remain off work for one month.

Dr. Galbraith testified that she discussed MW's lupus with her and Dr. Galbraith examined MW's elbow. Dr. Galbraith's notes of that examination record that Dr. Galbraith examined MW's range of motion in her neck, shoulders, elbows, wrists and hands, finding the range to be normal. The notes go on to indicate that Dr. Galbraith concluded that MW's sedentary administrative job duties would not result in the repetitive wrist flexion, gripping and twisting that would typically give rise to lateral epicondylosis.

Dr. Galbraith recalled that during the appointment, MW did advise that Dr. Lacaille had given her an injection during the March 7, 2016 appointment.

MW recalled that Dr. Galbraith expressed the view that MW could return to work but Dr. Galbraith thought it best to wait for Dr. Lacaille's report before making a final decision.

She went on to say that Dr. Lacaille's report was sent to the OHD shortly after that appointment.

At the hearing, MW was shown some OHD nursing notes of Ms. Martins dated March 30, 2016 indicating that through an anonymous tip, concerns had been brought to the OHD's attention regarding MW's disability claim because, while away from work, she had reportedly been caring for a two year old child on a full-time basis. The concern expressed was that if MW was able to perform those child care duties, she should also be able to perform the sedentary duties required in her job.

MW testified that those concerns were never raised with her by Dr. Galbraith during the March 31, 2016 appointment or at any time following that appointment.

Ms. Martins testified that the anonymous tip was received by the OHD after Ms. Martins had already scheduled the March 31, 2016 appointment with Dr. Galbraith.

Dr. Galbraith said that following her March 31, 2016 appointment with MW, Dr. Galbraith received a copy of Dr. Lacaille's report, which she reviewed. It did not mention any recommendation that MW remain off work for another month after the injection.

Dr. Galbraith went on to say that, based on her examination of MW, the improvement in her symptoms and the contents of Dr. Lacaille's report, Dr. Galbraith concluded that MW could attempt a graduated return to work with a number of specific restrictions. Dr. Galbraith's medical notes indicate those restrictions included MW working four hours a day with frequent breaks, pacing her work activities and an ergonomic assessment being undertaken by RTA.

On April 5, 2016, Dr. Galbraith phoned MW both to relay that information and to suggest that MW discuss the return to work plan with her physician.

Later that same day, Dr. Galbraith wrote an email to MW's supervisor advising that it was Dr. Galbraith's opinion that MW was fit to return to work with certain specified measures and restrictions in place.

Dr. Galbraith testified that she was aware of the anonymous tip that had been received by the OHD regarding MW's alleged babysitting while in receipt of DIP benefits; however, Dr. Galbraith said that information played no role in her assessment of MW's fitness to return to work.

Dr. Galbraith said that she did not contact MW's treating physician directly, as it was not the OHD practice to do that.

MW testified that after her discussion with Dr. Galbraith, MW was contacted by her supervisor inquiring as to why MW had not returned to work on April 6, 2016. MW recalled that she told her supervisor that she intended to return to work on the date indicated by her physician in his March 15, 2016 Physician's Report; i.e. April 15, 2016.

MW subsequently visited her family physician on April 14, 2016. He provided a Physician's Report indicating that MW could return to work on April 18 on the basis of the restrictions recommended by Dr. Galbraith. MW returned to work on that date. She was not paid DIP benefits for the April 6 to 18, 2016 period.

MW said that following her initial return to work in her department she was subsequently moved to a position in another department (the lab) on May 2, 2016. Dr. Galbraith testified that she saw

MW on April 28, 2016 in order to assess MW's fitness to work and possible accommodation measures given that she was scheduled to begin work in a different department on May 2, 2016.

At the end of the April 28, 2016 appointment, Dr. Gallagher concluded that MW was fit to work, with the same protective measures that had been in place previously. Dr. Galbraith arranged for MW to be seen by Dr. Davis on May 13, 2016 to assess her ability to function at work.

MW testified that Dr. Galbraith did not explain the purpose of the April 28, 2016 appointment.

MW said that when she went to the lab to begin work, the managers in that department reviewed her medical restrictions and expressed the view that it was clear that she was unable to do her assigned job. As a result an appointment was made with Dr. Galbraith for May 28, 2016.

On May 2, 2016, MW independently went to the OHD to report that her symptoms had become worse and that she needed to leave work as a result.

Ms. Martins then requested a follow-up from MW's family physician and on May 6, 2016 he provided a report indicating that MW was also now suffering from tension headaches. That report indicated an anticipated return to work date of May 16, 2016.

MW attended the appointment with Dr. Davis on May 13, 2016 but could not recall Dr. Davis advising her of the purpose of that appointment.

MW was requested by the OHD to undergo a Functional Abilities Evaluation which was performed on June 1, 2016 by a registered physiotherapist to assess appropriate accommodation measures in light of her new symptoms. That evaluation suggested that a graduated return to work be attempted with a number of identified restrictions and measures in place once MW's headaches had resolved.

On June 8, 2016, MW's treating physician provided a report indicating a diagnosis of tension headaches and expressing the view that MW was totally disabled with an anticipated return to work date of July 6, 2016.

MW was then referred to Dr. Humberto Martinho, another OHD physician, who met with her on July 8, 2016. Following that appointment, Dr. Martinho recommended that a partial return to work with restrictions be attempted on a trial basis beginning August 8, 2016. However, on August 4, 2016, MW's family physician again provided an assessment that MW was still totally disabled.

Dr. Martinho saw MW again on August 17, 2016. His medical notes indicate that she had developed new symptoms, which were being investigated. Dr. Martinho concluded that MW's symptoms had worsened and that she was unable to return to work. Dr. Martinho referred her for an IME. That referral prompted a response from the IME physician that another referral for an IME would not likely be particularly useful.

Kristen Metz, an OHD nurse, contacted MW on September 14, 2016 to make inquiries about MW's status. MW indicated she was suffering from headaches and dizziness. A computer tomography scan (CT scan) was scheduled by MW's treating physician for September 26, 2016 in respect to those symptoms.

On October 19, 2016 Ms. Metz contacted MW to follow-up on the CT results, which MW agreed to provide to the OHD. On November 17, 2016 Mr. Metz again contacted MW about the CT scan and MW advised the results were normal.

An appointment with the OHD was subsequently arranged for MW for November 21, 2016 to discuss a possible return to work plan. MW met with Jean-Claude Migneault, an OHD medical consultant. MW testified that the purpose of that visit was not explained to her.

In that appointment, MW provided her written consent to have the CT scan report and Dr. Lacaille's most recent report released to the OHD.

On December 9, 2016, MW's treating physician provided another report indicating MW was disabled with a possible return to work in six weeks.

MW was subsequently referred to an appointment with Brad Marash, another OHD medical consultant on December 19, 2016. MW said the purpose of that visit was also not explained to her.

On December 21, 2016, MW's physician wrote another report indicating MW was disabled with a return to work date of February 22, 2017.

MW testified that she has not been asked to attend any further appointments with OHD medical staff.

SR

SR suffers from anxiety, depression and hypertension and is totally disabled from work. He has been off work since January 25, 2016.

On November 27, 2015, SR submitted a DIP application attaching a Physician's Report completed by his physician, Dr. Mills. The report indicated that SR was totally disabled with an anticipated return to work date of December 3, 2015. That report provided a diagnosis of volatile hypertension and insomnia.

SR testified that he was unable to work on November 27, 2015 as a result of his blood pressure, which he said his physician had trouble controlling. SR attributed the source of the increased blood pressure as being the requirement for him to work mandatory overtime during the modernization program at the smelter.

In his report, Dr. Mills expressed the view that SR should be excused from having to work mandatory overtime.

Dr. Mills testified that SR indicated that he had had disagreements with managers in respect to the requirement to work mandatory overtime.

Dr. Mills said that he concluded that dynamic was contributing to SR's anxiety and hypertension.

SR returned to work later in December 2015. On January 6, 2016, SR's supervisor wrote to the OHD requesting that an appointment be arranged to have SR seen by Dr. Galbraith in light of SR having provided a physician's note indicating that SR was unable to work overtime.

An appointment was scheduled for SR to be seen by Dr. Galbraith on January 12, 2016.

In response to a question regarding what the lack of clarity in Dr. Mills' report might have been that would have caused the OHD to schedule the appointment, Ms. Martins explained that the statement that SR be excused from working overtime was much more like an accommodation measure and raised questions such as, if he was unable to safely work overtime, was he fit to be at work at all, or, was he unable to work all overtime or was he able to work some if there were breaks?

SR declined to attend the January 12, 2016 appointment with Dr. Galbraith because he believed Dr. Mills had already provided sufficient information. SR said that he and his manager had an altercation, which ultimately resulted in SR receiving a five day suspension. SR was subsequently transferred to another part of the smelter.

Dr. Mills testified that he saw SR on January 12, 2016. During that appointment, SR indicated that he had been having arguments with management regarding his being required to work mandatory overtime and SR indicated that he had been disciplined at work as a result.

Dr. Mills' notes of that appointment indicate that SR advised that he had been told by RTA managers that a medical opinion would be required before he could be excused from having to work the mandatory overtime.

On January 25, 2016 SR suffered a panic attack while at work and saw Dr. Mills that same day. Dr. Mills provided a report indicating that SR was not fit to return to work, with a diagnosis of anxiety, panic attacks and depression.

The OHD nursing notes indicate that an OHD nurse attempted to contact SR on February 3, 2016 regarding the Physician's Report and left a message asking SR to return the call to discuss that matter.

SR testified that he did not receive that message.

Dr. Mills saw SR several times in February, 2016, noting that SR remained anxious and suffered from ongoing hypertension.

Dr. Mills provided a further report on February 25, 2016 confirming the original diagnosis and indicating that SR was totally disabled. The Physician's Report contains a space for an employee to sign indicating their consent for the release of medical information to OHD. SR did not sign the form providing his consent.

On February 26, 2016, SR's manager left a message for SR indicating that an appointment had been scheduled on March 4, 2016 and that SR should sign the consent form in order to allow the OHD physician to obtain medical information from Dr. Mills.

SR returned that call and had a conversation with his manager on February 29, 2016. SR testified that in that conversation, his manager confirmed the information relayed in his February 26 message to SR, but did not indicate that the requested consent was contained on the Physician's Report which had been completed by Dr. Mills. SR recalled that his manager advised that if SR refused a referral to the OHD physician, SR would be required to meet with the manger. SR also recalled telling his manager that that he was not prepared to see the OHD

physician because he continued to believe that Dr. Mills had already provided all necessary medical information.

SR testified that he then went to see Dr. Mills to report that his manager was contacting him at his home which was causing SR considerable distress.

Dr. Mills referred SR to a specialist who, on March 2, 2016 confirmed the diagnosis of volatile hypertension. On March 2, 2016, Dr. Mills saw SR. Dr. Mills testified that SR's blood pressure was elevated and SR reported that he had fainted at home and while driving his vehicle. Dr. Mills said that information raised significant concerns for him causing him to write his March 2, 2016 letter to Dr. Galbraith. That letter advised of SR's extreme anxiety at work and opined that approaches to SR by his manager at work had caused SR to suffer panic attacks and to pass out while at work. In that letter Dr. Mills went on to say that until SR's hypertension and anxiety were successfully treated, his manager should not approach him at work.

In that letter Dr. Mills also requested Dr. Galbraith's comments.

Dr. Galbraith received that letter on March 4, 2016 and that same day faxed a letter to Dr. Mills asking if he had SR's consent to speak with Dr. Galbraith. Dr. Mills was not in his office that day.

On March 4, 2016, Ms. Martins wrote to advise several RTA managers, including SR's manager advising that SR's manager should not contact SR.

Later that day, Dr. Galbraith also wrote an email to RTA managers indicating that Dr. Mills was treating SR, that Dr. Galbraith did not have SR's signed consent to speak with Dr. Mills in order to fully understand the medical issues and that SR was not cleared to return to work or to attend work to meet with management. That email went on to state Dr. Galbraith's opinion as being that SR was not fit for work at that time.

Ms. Martins testified that SR's manager would not have been aware of SR's diagnosis of anxiety and hypertension.

SR did not attend the March 4, 2016 appointment. Dr. Galbraith testified that she believed that appointment had likely been arranged for SR to meet with his manager, not the OHD.

On March 9, 2016, SR's manager sent an email copied to the OHD, expressing frustration regarding SR's perceived lack of co-operation and expressing the view that his DIP benefits should be discontinued until SR was prepared to be more co-operative.

Dr. Galbraith responded by email stating that she was unable to comment on administrative decisions and was unable to clarify the medical issues until she could speak to SR's physician. Dr. Galbraith testified that her intent was to indicate to the manager that her role was to focus on medical issues and whether an employee is fit to return to work, not on whether an employee was co-operative or not.

On March 10, 2016, SR's manager telephoned SR and left a message advising that SR's DIP benefits would be suspended until he either signed the consent to have the medical information in the Physician's Report shared with the OHD or agreed to an appointment with Dr. Galbraith. That same day, SR's manager wrote an email to other members of RTA management advising that he had left a message for SR indicating that SR's DIP benefits would be discontinued until he provided sufficient information including the signed consent.

Dr. Galbraith was not copied on that email at that time.

On March 11, 2016, the Union contacted the OHD to inquire about the purpose for the OHD's request for medical information. The OHD staff advised that SR had not provided his consent on the last Physician's Report which was required in order for Dr. Galbraith to contact and speak with Dr. Mills. The OHD also advised that the OHD had been unable to contact SR. The Union indicated it would have SR sign the consent and send it to the OHD.

SR testified that he was unaware that it was necessary for him to provide his consent through the Physician's Report and when the Union clarified that fact, he provided his consent.

On March 11, 2016, SR left a message for his manager indicating that he intended to provide all the necessary information including a signed consent. That same day the Union faxed a copy of the signed consent to the OHD.

There was no interruption to SR's DIP benefits.

Dr. Galbraith explained that she did not believe it was appropriate for her to speak with Dr. Mills until she had received SR's consent for the release of medical information by Dr. Mills.

Dr. Galbraith received the signed consent form on March 18, 2016 and that same day she faxed it to Dr. Mill's office and attempted to contact Dr. Mills by phone to speak with him. However, Dr. Mills was out of his office until March 21, 2016. On March 21, 2016, Dr. Galbraith telephoned Dr. Mills' office; however the office was closed due to a power outage.

Dr. Galbraith testified that she has a long-standing and very positive working relationship with Dr. Mills. She said that she called Dr. Mills because he had requested her input and comments in respect to SR. Dr. Galbraith said that she saw her role as being to work together with Dr. Mills to clarify the diagnosis and treatment recommendations but not to manage SR's treatment. Dr. Galbraith explained that in order for her to understand SR's work restrictions and properly make a fitness to work determination, it was necessary for her to fully understand the diagnosis and treatment plan. She indicated that she did not fully understand one of the conditions noted by Dr. Mills and needed clarity in respect to it.

On March 23, 2016 Dr. Galbraith was finally able to speak with Dr. Mills. In that conversation they discussed SR's medical status. Dr. Galbraith suggested, and Dr. Mills agreed, that SR should be referred to a psychiatrist- Dr. Alan Buchanan in Vancouver.

Dr. Galbraith said that Dr. Mills had indicated that SR was too anxious to speak to anyone at work but Dr. Mills did not know the reason or source of SR's anxiety. Dr. Galbraith said more information was useful in order to properly assess any possible accommodation measures for SR.

Dr. Galbraith's notes of that conversation indicate that she and Dr. Mills agreed to work together in terms of an improved management of SR's medical conditions and for his possible return to work. Those notes also indicate they agreed to a number of steps to be taken in that regard.

SR recalled that Dr. Mills told him that Dr. Mills had spoken with Dr. Galbraith and they had discussed a referral to Dr. Buchanan.

An appointment was then arranged for SR with Dr. Galbraith, which he attended on March 31, 2016. Dr. Galbraith testified that it was a positive meeting which included a discussion about a referral to Dr. Buchanan, which SR agreed to. She noted that SR was very co-operative during that appointment.

SR testified that he was not advised of the purpose of his appointment with Dr. Galbraith when the appointment was made. However, he recalled that during the appointment, Dr. Galbraith did explain its purpose to him.

SR then saw Dr. Buchanan who wrote a report which was sent to Dr. Galbraith as the referring physician. She forwarded the report to Dr. Mills.

Dr. Galbraith then met with SR on April 29, 2016 to follow-up on Dr. Buchanan's report. Following that appointment with SR, Dr. Galbraith concluded that SR was totally disabled. That appointment was her last contact with SR.

SR testified that he understood the purpose of the April 29 appointment with Dr. Galbraith as being a follow-up to review and discuss Dr. Buchanan's report.

Dr. Galbraith acknowledged that a further appointment was arranged (which did not occur) for SR to see her on June 10. 2016. She said the purpose of that appointment was to give SR an opportunity to follow-up with Dr. Mills to discuss a plan and then return to see Dr. Galbraith regarding SR's fitness to return to work.

Dr. Galbraith acknowledged that it was unlikely that she had advised SR that she was not SR's treating physician. When asked at the hearing if she understood her role to involve the diagnosis and treatment of SR she responded she did not. Rather, she said she understood her role as being to clarify the diagnosis and treatment plan made by Dr. Mills and its impact on SR's ability to return to work.

In response to a question regarding why Dr. Galbraith found it necessary to see SR given that he was being treated by Dr. Mills and had been seen by Dr. Buchanan, Dr. Galbraith noted that she only saw SR twice going on to say that she and Dr. Mills agreed that she should see SR as she was able to expedite a referral to Dr. Buchanan. In addition, as the referring physician, she needed to provide a reasonable amount of information in her referral letter, which was best obtained through an appointment with SR.

Dr. Galbraith went on to explain that, as the referring physician, she was professionally obliged to follow-up with SR upon her receipt of Dr. Buchanan's report.

SR was subsequently seen on July 8, 2016 and August 3, 2016 by Dr. Martinho to discuss a possible return to work sometime in August. However, Dr. Martinho's file notes of August 3, 2016 indicate that between those two visits a new medical issue (seizures) had arisen, making it impossible for SR to return to work at that time.

SR testified that he did not recall the purpose of those meetings being explained to him by OHD staff.

SR was subsequently referred to Mr. Morash, for several follow-up visits as part of the fitness to return to work assessment process in the context of SR undergoing a number of ongoing medical tests.

AD

AD has been employed with RTA since 1988. He was injured at work on November 13, 2015. He was seen by the RTA first aide attendant and he returned to work for the remainder of his shift. However, AD called in sick for his next shift due to a reported neck injury.

AD made a WorkSafeBC claim which was accepted. He was subsequently accommodated by the Employer and returned to work on modified duties.

Ms. Martins testified that on November 16, 2015, AD's supervisor requested that an appointment be made for AD to be seen by Dr. Galbraith, which was done. Ms. Martins said that it is not uncommon for RTA supervisors or managers to request that an injured employee be seen by an OHD physician to determine the employee's fitness to work.

Ms. Martins went on to explain that AD's appointment with Dr. Galbraith was subsequently cancelled by the RTA Safety Co-ordinator.

AD testified that while at work on modified duties he re-injured himself. He went on to say that he independently went to the OHD to request some information regarding possible modified duties and was referred to an appointment with Dr. Galbraith for that purpose.

Ms. Martins testified that shortly after AD's return to work, he independently approached the OHD requesting information about his possible accommodation or modified duties options. He requested an appointment with Dr. Galbraith for that purpose, which was arranged for March 4, 2016; however, he subsequently cancelled that appointment.

Ms. Martins recalled that during her discussion with AD, she advised him that he had the option of seeing either his family physician or Dr. Galbraith. AD indicated his preference was to have the OHD assist him in managing his identified restrictions; however, he ultimately decided to see his family physician instead.

AD acknowledged that he requested an appointment with Dr. Galbraith which he later cancelled. He agreed he was not opposed to seeing Dr. Galbraith and also agreed that the OHD had not "pursued" him for an appointment.

AD also agreed that if his family physician had not been available for an appointment, he would have been happy to have seen Dr. Galbraith.

Positions of the Parties

Policy Grievance

There is no real controversy regarding the general legal principles attaching to employee privacy interests in the context of confidential employee medical information. The essential disagreement between the parties relates to the application of the general principles in the

circumstances of this case. Accordingly, I find it only necessary to briefly summarize the parties' characterizations of those general principles.

The Union

In essence, the Union submits that the critical importance of employee privacy rights is well established. In that context, an employer does not have an inherent right to intrude on employee privacy rights by requiring an employee to see a physician of an employer's choice. Any such right must be found in the express language of a collective agreement and where such a right exists, its exercise is constrained by the requirement that an employer must adopt the least intrusive measures in seeking reasonably necessary medical information, which is relevant to a disability claim.

The Union says that the exercise of that right by an employer must be the "last resort": *Telus Communications Co. v Telecommunications Workers Union* (2010) C.L.A.D. No. 11 (Lanyon) ("Telus"); *West Vancouver Fire Fighters' Union Local 1525* (2012) B.C.C.A.A.A. No. 166 (Hall) ("West Vancouver"); *Hamilton Health Sciences v Ontario Nurses Assn.* (2007) 16 L.A.C. (4th) 122 (Surdykowski) ("Hamilton").

The Union says that giving proper effect to the application of those principles in the circumstances of this case requires that the Employer adhere to the following staged approach.

Medical information should first be obtained by the OHD from an employee's treating physician. That information should be limited to that which is reasonably necessary to determine whether the employee is eligible for DIP benefits. Where the Employer has a reasonable basis for doubting the accuracy or truth of the information provided, the OHD may seek clarification from the employee's treating physician.

Where there is a reasonable basis for the OHD to believe that the information provided is unreliable or insufficient and a more expert opinion is required, the employee should be able to obtain the information sought through a specialist of the employee's choice.

Where that is done and a reasonable basis for uncertainty remains, the employee should be referred to a physician that is mutually agreeable to the employee and the Employer.

Once those options have been explored and some legitimate doubt remains, it is only at that point that the Employer is entitled, as a last resort, to have the employee seen by a physician of the Employer's choice.

In general terms, the Union submits that the Employer has acted unreasonably in the manner in which it obtains medical information. The Union argues that, in requiring employees in receipt of DIP benefits to undergo examinations by the OHD physicians, the Employer has breached Article 37.10 of the Collective Agreement and has overstepped any right existing under the Collective Agreement to collect medical information, through the manner in which those consultations occur.

The Union says that the Employer's actions are unreasonable and constitute an arbitrary intrusion on employee's dignity and privacy.

The Union goes on to submit that when an OHD physician examines an employee, as is reflected in the circumstances of the individual grievances in this case, there is no explanation

or specific reason for the examination provided to employees. Nor is the role of the OHD physician explained, nor is it made clear to employees that the OHD physician is not the employee's treating physician.

The Union asserts that RTA managers typically question the legitimacy of DIP claims and direct employees to attend appointments with the OHD physicians as result.

The Union submits that those examinations are open-ended in that they do not focus on specific concerns arising from the medical information provided by, or available from, the employee's treating physician.

The Union argues that employees are also asked to sign open-ended consents which allow the release of medical information which is well beyond the information contained on the Physician's Report.

The Union goes on to assert that OHD physicians make fitness to work determinations without the input by or consultation with the employee's physician, and which may even contradict the opinion of the employee's treating physician.

The Union asserts that typically once employees are examined by the OHD physician, they are subsequently scheduled for follow-up visits with the OHD.

The Union argues that the role of the OHD physician is well beyond what is contemplated in the Collective Agreement and constitutes a significant and unwarranted intrusion into employee privacy interests.

The Union says that OHD physicians are retained by RTA, they perform examinations of employees on behalf of the Employer, often at the request of RTA managers. They work on-site and are dependent on the Employer as a source of their income and are not chosen by mutual agreement.

The Union argues that OHD physicians act as decision makers on DIP claims.

The Union submits that while Dr. Galbraith insisted the OHD operated on an arms-length basis from the Employer, the OHD does not in fact function like an independent medical clinic. Rather, the role of the OHD physician is to provide opinions to RTA to determine an employee's eligibility for DIP benefits.

The Union says that the Employer's policies regarding the operation of the OHD reflect an unwarranted intrusion into the privacy of RTA employees. More specifically, it is asserted that the policies contemplate that the OHD physician acts as a medical liaison between medical providers, specialists, the injured or ill employee and the family and management. The policies also contemplate the OHD physician taking an active role in the case management of injured or ill employees from initial treatment to closure of the file.

The Union says its privacy concerns have two central aspects. First, it is alleged that employees are not provided with sufficient information regarding the nature and purpose of the appointments with the OHD physician. It is asserted that the lack of disclosure regarding the purpose of those visits is compounded by the apparent lack of clarity that the OHD physicians act on behalf of RTA and do not operate on an arms-length basis from the Employer.

Second, it is asserted that the Employer uses the OHD to gather more medical information than it should reasonably have access to. In the process of doing that, the Employer inserts the OHD physicians into the diagnosis and treatment of employees.

The Union submits that the OHD physicians act on the understanding that their role involves the diagnosis and treatment management of employees. The Union goes on to say that the OHD is part of the Employer and it is inappropriate for the Employer to be involved in the diagnosis and treatment of its employees which is properly the role of the employee's treating physician.

The Union argues that, as was acknowledged by Ms. Martins, there is no policy or guidelines used to determine whether an employee should be seen by the OHD staff. Rather, that decision is made on a case by case basis.

The Union submits that while it accepts that most DIP claims are approved on the basis of the information in the Physician's Report provided to the OHD by an employee's treating physician, nonetheless, the evidence of the individual grievors bears out the Unions concerns regarding the over-reaching nature of the Employer's policy and practice.

The Employer

The Employer takes no real issue with the general privacy principles as discussed in *Telus* and *West Vancouver.*

In essence, the Employer says that the Collective Agreement, viewed in the larger context, should provide the framework for the determination to be made in this case. In that regard, the Employer argues that Article 37 contemplates that the Employer will provide wage loss protection to eligible employees who suffer non-work related illness or injury. Article 37 sets out the eligibility requirements which employees must meet, which include the right of the Employer to have employees examined by a physician of its choice (Article 37.10) and for the OHD to make the final determination regarding whether an employee is totally disabled.

The Employer says that Article 37.09 (a) contemplates that DIP benefits may be stopped if the OHD determines that an employee is no longer disabled.

The Employer submits that the clear purpose of the OHD is to maintain a safe and healthy workplace and to ensure that employees are capable of performing their job duties. The OHD has been in place for at least three decades using the practices and procedures which are only now challenged by the Union, in particular the role of the OHD physician.

The Employer accepts the importance of employee privacy and the need for it to be respected. The Employer goes on to submit that the parties have negotiated a provision in the Collective Agreement in Article 37.10 (a) that expressly contemplates a right for the Employer to refer an employee for a medical examination and for the disclosure of relevant medical information. The Employer submits that there is a long-standing, unchallenged practice giving effect to that provision which has been consistently applied for more than 30 years.

The Employer argues that, based on the language of the Collective Agreement, and consistent with the parties' long-standing practice, the parties have agreed to have the OHD operate in the manner disclosed on the facts of this case, including the role of the OHD physician.

The Employer submits that the "least intrusive means" standard adopted in the *Telus* and *West Vancouver* cases does not apply in the circumstances of this case, particularly given the decades of unchallenged practice by the OHD.

The Employer goes to argue that, in the event the least intrusive means standard is found to apply, the Employer's policies in respect to the manner in which the DIP benefits are administered in determining the *bona fides* of employee absences, the timing of any return to work and in determining what, if any, accommodation may be required are in any event, consistent with that standard.

The Employer reiterates that the decades of unchallenged practice, which reflects the unique circumstances of this case, should inform the least intrusive means analysis. In that regard the practice reflects how the OHD has historically operated and continues to operate and is consistent with the application of the standard in the circumstances of this case.

The Employer goes on to note that, unlike many collective agreements, this Collective Agreement is unusual because it expressly and specifically recognizes the Employer's right to refer an employee to a physician of the Employer's choosing. The Employer submits that the long-standing practice is also useful and should be relied upon for the purposes of the interpretation of Article 37 and other relevant portions of the Collective Agreement.

The Employer argues that, on the evidence, the OHD does not share employees' medical information with RTA supervisors, managers or labour relations staff. Moreover, the minimum necessary amount of information is shared with an employee's worksite.

The Employer says that while the OHD physicians are paid by RTA and are involved in the assessment of employees' receipt of DIP benefits, that role is expressly contemplated in the Collective Agreement. The role of the OHD, including that of the OHD physician, has been in place for decades and during that time, numerous cases have been dealt with using the same practices which are now challenged for the first time, with the agreement of both employees and the Union.

The Employer submits that employees who visit with the OHD staff understand that such appointments are part of the DIP process, which is a benefit employees are only entitled to under the Collective Agreement if they are eligible. As part of that process, Article 37.10 expressly recognizes the Employer's right to request that an employee see the OHD physician.

The Employer says that there is nothing inappropriate or inconsistent with the Collective Agreement for the OHD to not provide employees with exact information regarding the nature and purpose of an examination by the OHD physician.

The Employer concedes that the OHD has not, on a regular basis, consulted with the employee's treating physician as to whether the employee is disabled as set out in Article 37.01 (a), 37. 09(a) and 37.10 (a). However, it argues that Article 37.10 recognizes that the OHD decision regarding whether an employee is disabled is final. Any lack of consultation that may be found does not mean the OHD decision regarding whether an employee is disabled is wrong or should somehow be voided.

The Employer advised that, going forward, it is prepared to ensure that OHD medical professionals consult with employees' treating physicians.

Individual Grievances

Union

MW

The Union submits that RTA received an anonymous tip, apparently from an RTA supervisor, raising concerns relating to MW's babysitting of a two year old child while also in receipt of DIP benefits, expressing doubts about the *bona fides* of her absence and receipt of DIP benefits which was placed on her OHD file.

The Union goes on to say that the fact the information was kept in that manner is of considerable concern. The Union asserts that that reflects the fact that the OHD does not have an arms-length relationship with RTA and that RTA managers have an open channel of communication to the OHD. The Union argues than an independent physician, such as a family physician, would not collect or retain such information relating to the potential legitimacy of their patient's condition, on the physician's file.

The Union says that the OHD's original interview with MW involved what is characterized as an open-ended discussion of her medical history, condition and treatment. The Union alleges that discussion was not directed to a particular and legitimate concern relating to any insufficiency in the information that had been provided by MW's treating physician.

The Union argues that the Employer, through the OHD, requested a report from MW's specialist without any explanation or justification.

The Union submits that Dr. Galbraith agreed that she had not consulted with MW's treating physician or Dr. Lacaille prior to concluding that MW was fit to return to work and, in fact, acknowledged that it was not her practise to consult with an employee's treating physician.

The Union asserts that Dr. Galbraith made the determination that MW was fit to return to work in contradiction to the opinion that had been previously provided by MW's treating physician that she not return to work until April 15, 2016.

The Union goes on to say that that failure to comply with the Collective Agreement obligation on the Employer to consult with the employee's physician means that the Employer did not have the right to deny MW's DIP benefits for the eight day period that it did.

The Union says that Dr. Galbraith provided the Employer with an opinion regarding whether MW was totally disabled and the Employer relied on that opinion to suspend MW's DIP benefits. The Union challenges Dr. Galbraith's assessment that MW was fit to return to work.

The Union submits that the Employer, through the OHD, required MW to continue to be seen by OHD medical staff, including a medical consultant who is not a physician, all of which it is asserted constituted an unreasonable intrusion on her privacy.

The Union goes on to say that either Dr. Lacaille or MW's treating physician would have constituted less intrusive sources of information regarding MW's fitness to return to work.

The Union argues that MW was, on her return to work, ultimately placed in a position that was clearly unsuitable for her medical restrictions. Consequently, the Employer's assertion that Dr. Galbraith's examination of MW was related to a return to work assessment and accommodation is baseless.

SR

The Union submits that SR's manager initiated an appointment with Dr. Galbraith. The Union goes on to allege that the purpose of the medical examination related to SR's ability to work mandatory overtime and had nothing to do with any legitimate uncertainty about SR's return to work or his accommodation.

The Union says that the referral to the OHD was based on SR's manager's opinion that SR should have been performing overtime work.

The Union argues that SR's circumstances illustrate that when RTA management want a medical examination to be undertaken by the OHD, one will be arranged, which also reflects the fact that the OHD does not operate in the arms-length manner from the Employer as suggested by the Employer. As well, the Union says that it is apparent that RTA managers and the OHD share medical information and work together beginning with the ability of a front- line manager to cause an appointment with an OHD physician to be scheduled.

The Union says that in his report, Dr. Mills clearly stated SR's medical restrictions were in respect to his ability to work overtime as a result of his volatile hypertension. The Union asserts that, to the extent to which there may have been any legitimate doubt or uncertainty regarding Dr. Mills' report, the Employer should have followed up with Dr. Mills. Instead, the Employer chose to have an appointment with Dr. Galbraith arranged.

The Union goes on to note that SR was not provided with any explanation regarding the purpose of his appointment with the OHD physician and when he refused to attend the appointment, he was disciplined.

The Union says that, on the evidence, SR saw Dr. Galbraith as his treating physician which is illustrated by his testimony to the effect that Dr. Galbraith was "trying to get him better" and his express view that "the more doctors the better".

The Union submits that the OHD received Dr. Mills' March 2, 2016 letter expressing the opinion that SR's manager should not contact him. That information was relayed by the OHD to the manager who, nonetheless, contacted SR.

The Union argues that while Dr. Galbraith indicated the purpose of her March 31, 2016 appointment with SR was to clarify the nature of SR's condition and as a result of Dr. Mills request for input, there was nothing in Dr. Galbraith's assessment that was conditional on any further inquiries by or appointments with the OHD.

The Union says that Dr. Galbraith had no particular expertise to add to the information that had already been provided by Dr. Mills.

The Union submits that the Employer was provided with an abundance of medical information from Dr. Mills and, notwithstanding the fact that SR had neglected to sign the consent form, the

Employer had more than enough information regarding his medical condition or restrictions. Consequently, it asserts there was no legitimate basis for a follow-up examination by Dr. Galbraith. In fact, Dr. Galbraith ultimately concluded SR was totally disabled without having seen him.

The Union argues that even if the Employer had a legitimate basis for seeking additional information, it should have simply requested an expert report from a mutually agreed to physician. Consistent with the application of the least intrusive measure principle, it was not necessary to involve Dr. Galbraith at that point in time.

The Union goes on to say that notwithstanding Dr. Buchanan's opinion that SR was totally disabled, the OHD required SR to continue to be examined by OHD medical staff including its medical consultants on an ongoing basis. The Union alleges that the nature of those inquires was open-ended and unrelated to specific and legitimate concerns arising from information that had been provided by Dr. Mills.

The Union submits that the OHD assumed the role of providing ongoing care management of SR which is, under the Collective Agreement, clearly the role of the employee's treating physician.

The Union argues that RTA managers were involved in the efforts to have SR examined by an OHD physician and his medical information collected.

The Union says that the conduct of SR's manager illustrates how the right to request employee medical information can be misused. In SR's circumstances it was used as a lever to attempt to investigate SR's alleged misconduct.

The Union alleges that the lack of SR's consent on Dr. Mills' report was simply a pretext for a meeting to be arranged between the OHD and SR notwithstanding the fact Dr. Mills had found SR to be unfit to return to work.

The Union argues that the Employer had no legitimate basis to threaten to suspend SR's DIP benefits or to continue to attempt to have him agree to an appointment with the OHD physician.

AD

The Union submits that AD was asked to see an OHD physician almost immediately following his injury at work. The Union says that AD's treating physician provided information which was not challenged and his WorkSafeBC claim was approved. The Union asserts that the information provided by AD's treating physician should have been sufficient without any need for an examination by the OHD physician.

The Union says that AD did not request an appointment and, in any event, the March 2, 2016 scheduled appointment was well after AD's initial accommodation and well after the Employer had sought to have him seen by the OHD physician.

The Union goes on to say that the fact an employee has suffered a workplace injury does not provide a sufficient or reasonable justification for the Employer to require the employee to submit to an examination by the OHD physician.

The Union asserts that any uncertainty regarding AD's medical restrictions could have been resolved by the OHD contacting his treating physician.

The Union submits that notwithstanding the fact that AD's treating physician had provided information regarding his medical condition and restrictions, and the fact AD was approved to receive WorkSafeBC benefits, the Employer nonetheless required AD to see an OHD physician and to that end, booked an appointment with the OHD physician.

Employer

MW

The Employer submits that its ongoing duty to accommodate MW's chronic medical condition and ensuing communication obligations, required the OHD to keep in touch and up to date with MW's medical condition. The Employer says that the March 17, 2016 Physician's Report that the OHD received indicated a diagnosis simply as being "elbow" with an anticipated return to work date of April 15, 2016. The OHD concluded that in those circumstances, some follow-up was necessary as a result of the lack of clarity in terms of the diagnosis.

The Employer argues that the clear purpose of the follow-up calls and appointments with MW was to determine her fitness to return to work and whether there were accommodations that were required to facilitate her return to work.

The Employer says that Dr. Galbraith assessed MW's fitness to return to work and MW's physician agreed with Dr. Galbraith's assessment that MW was in fact fit to return to work on the basis of the return to work plan proposed by Dr. Galbraith.

The Employer goes on to say that the communication and inquiries made by the OHD in respect to MW's medical circumstances were in furtherance of the Employer's duty to accommodate, which includes a requirement to communicate with a sick or injured employee. The Employer submits that follow-up by the OHD was not arbitrary or unreasonable but was for the legitimate purpose of determining MW's fitness to return to work and in order to develop a graduated return to work plan.

The Employer submits that on the evidence of Ms. Martins and Dr. Galbraith, the anonymous tip received by the OHD regarding MW's babysitting of a two year old child while in receipt of DIP benefits, played no part in the decision to have MW examined by Dr. Galbraith.

The Employer goes on to say that any failure by Dr. Galbraith to consult with MW's family physician does not deprive the Employer of the right under Article 37.10 of the Collective Agreement to have had MW seen by Dr. Galbraith, nor does it somehow deprive the Employer of the right to have made the decision regarding whether MW was disabled.

The Employer argues that Dr. Galbraith did examine MW and, as a specialist in occupational health medicine, made a valid determination regarding MW's fitness to return to work, which was within Dr. Galbraith's expertise and as is contemplated in the Collective Agreement.

The Employer goes on to note that while the Union alleges the MW was somehow "punished" by being placed in a different work area, the OHD had no role in that placement. Rather, Dr. Galbraith did what was necessary; i.e., she simply determined whether MW was fit to return to work.

SR

The Employer submits that SR did not sign a consent form which would have allowed Dr. Galbraith to speak with Dr. Mills. SR's manager attempted to have SR sign the consent or to have him agree to see Dr. Galbraith. The Employer goes on to say that, on the evidence, Dr. Mills was unable to say what caused SR's anxiety. Dr. Mills also suggested in his report that SR could not safely drive his personal vehicle, but said nothing about his ability to drive a vehicle at work.

The Employer submits that SR did not object to being seen by Dr. Galbraith and, in fact, he was receptive to that occurring. Moreover, the OHD had no involvement or role in any actions taken by SR's manager.

The Employer says that SR saw an OHD physician every two months in order to have his ability to return to work assessed. It was ultimately concluded that due to new medical conditions (seizures) a return to work would not be possible. The Employer goes on to say that follow-up appointments were scheduled by the OHD with SR in order to assess his potential to return to work following a number of medical tests he underwent.

The Employer submits that the OHD practice for many years has been for the OHD to refer employees to specialists. In that context, as the referring physician, the OHD physician receives a copy of the specialist's report, which does not constitute a privacy breach.

AD

The Employer says that following a workplace injury, AD's supervisor referred him to Dr. Galbraith to have her assess the extent of AD's injury and his fitness to work. An appointment for that purpose was made and subsequently cancelled.

The Employer says further that AD returned to work on modified duties. He then independently approached the OHD to request information about his modified duties program and an appointment was made with Dr. Galbraith to discuss his questions. AD subsequently cancelled that appointment.

The Employer submits that AD was never seen or examined by any OHD medical staff and there is simply no basis for a finding of any breach of the Collective Agreement in respect to him.

Remedy

Union

The Union seeks both declaratory relief and damages in respect to the alleged breach of employee privacy rights and the Collective Agreement.

More specifically, the Union submits that the Employer has not acted in a manner that is consistent with the well-established applicable privacy principles. The Union goes on to assert that the Employer acts unreasonably in the manner in which it obtains employee medical information. The Union says that the Employer's actions are inconsistent with the Collective Agreement particularly when viewed in the context of the fundamental importance of employee privacy rights and the requirement on the Employer to adopt the least intrusive means of obtaining any necessary employee medical information.

The Union seeks a declaration to that effect.

The Union also seeks damages for both the policy and individual grievances. More specifically, the Union submits that damages for a breach of employee privacy rights are an appropriate remedy which should properly reflect the fundamental importance of those rights. The applicable principles in that exercise involve, among others, the nature of the intrusion, its incidence, length of the occasion of the breach and its impact on employees: see *Rio Tinto Alcan v Unifor, Local 2301* (2014) B.C.C.A.A.A. No. 165 (Sullivan); *St. Patrick's Home of Ottawa v Canadian Union of Public Employees, Local 2437* (2010) O.L.A.A. No. 93 (Knopf) ("St. Patrick's").

The Union goes on to say that in *St. Patrick's*, the arbitrator found that while the employer's Human Resources Department in that case had acted in the honest belief that it was entitled to release confidential employee medical information, nonetheless, that release was deliberate and done without regard to the employer's confidentiality policy and without legal advice.

The arbitrator found the release constituted an intrusion into employee private medical affairs. In determining an appropriate damages remedy, the arbitrator commented that the upper range for such damages should be $ 20,000.00.

The Union contends that in this case, the Employer's unreasonable actions constitute not only an intrusion into employee privacy but also their medical status and treatment, which are well recognized as areas requiring real or significant protections.

The Union argues that in this case, the Employer unreasonably asks employees to see an OHD physician, then uses that opportunity to establish what the Union characterizes as an "on-going and open-ended window" into the employee's medical file as well as requiring employees to undergo examinations by the OHD for no legitimate reason.

The Union submits that the Employer, through the OHD, manages the care and treatment of its employees, which is improper.

The Union says that applying the applicable legal principles relating to employee privacy interests to the circumstances of this case should result in an award of damages at the higher end of the scale.

Turning to the individual grievors, the Union says the circumstances of those individuals reflect the nature of the intrusion effected through the Employer's policies and the practices of the OHD.

The Union seeks damages to compensate MW for the eight days for which she was allegedly improperly denied DIP benefits. The Union also seeks an award of $ 10,000.00 damages for the alleged breach of her privacy rights by the Employer.

The Union also seeks damages in the amount of $ 10,000.00 for the alleged breach of SR's privacy rights and an additional $ 10,000.00 for the actions of SR's manager which, it is alleged, caused SR significant mental distress and suffering: *Greater Toronto Airports Authority v Public Service Alliance of Canada, Local 0004* (2010) 191 L.A.C. (4th) 277 (Shime);

The Union also seeks punitive damages in the amount of $ 5,000.00: *Morison v Ergo-Industrial Seating System Inc.* 2016 ONSC 6725 para 49-52.

Finally, the Union seeks damages on behalf of AD in the amount of $ 5,000.00 for an alleged violation of the Collective Agreement by requiring AD to see an OHD physician and to that end, booking an appointment for him: *West Park Healthcare Centre v SEIU, Local 1* (2005) 138 L.A.C. (4th) 213 para 11; *Gateway Casinos* (2007) 159 L.A.C. (4th) 227 para 72.

The Union says that while AD's privacy rights may not have been actually impinged, the Employer nonetheless violated the Collective Agreement and therefore, there must be a real remedy attaching to that breach, particularly to ensure there are no future such breaches.

Employer

As noted earlier, the Employer submits that no breach of employee privacy rights is established. The Employer says that if it is found that breaches have occurred, the only appropriate remedy would be a declaration to that effect with some guidance provided regarding the applicable general principles and not damages.

The Employer submits that if a breach is found and it is concluded that a declaration is insufficient, the factors to be considered in determining an appropriate monetary remedy involve the nature, incidence and occasion of the breach, its effect on the employees including any distress, annoyance or embarrassment, the relationship between the parties and the conduct of the parties before and after the breach including any apology: *Labatt Breweries of Canada LP (Columbia Brewery) v Interior Brewery Workers' Union, Local 308* (2017) B.C.C.A.A.A. No. 30 (Saunders) ("Labatt").

The Employer says that in applying those factors, including in cases involving the release of confidential employee medical information, arbitrators have generally found that nominal damage awards provide an appropriate remedy, other than in exceptional circumstances: *Rio Tinto Alcan v Unifor, Local 2301* (2014) B.C.C.A.A.A. No. 165 (Sullivan) ($1,750 for each impacted employee); *Labatt* ($1,500.00 for each of the two affected employees); *St. Patrick's* ($1,000.00 to the affected employee); *Alberta v Alberta Union of Provincial Employees* (2012) A.G.A.A. No. 23 ($ 1,250.00- $2,750.00); *North Bay General Hospital v Ontario Public Service Employees Union* (2006) O.L.A.A. No. 533 ($750.00) ("North Bay"); *Hamilton Wentworth Catholic District School Board v Ontario English Catholic Teachers' Assn.* ($500.00 – relating to the disclosure of an employee's diagnosis and treatment plan) ("Hamilton").

The Employer notes that *St. Patrick's, North Bay* and *Hamilton* all involved privacy breaches by an employer in the context of confidential employee medical information which resulted in awards of between $500.00 and $ 1,000.00.

The Employer submits that if a breach is found in respect to the Employer's duty to consult with the employee's treating physician, the usual remedy for such a breach would be a declaration

with no monetary award: see for example *Western Pulp Ltd. Partnership v Pulp, Paper & Woodworkers of Canada, Local 3* (1994) B.C.C.A.A.A. No. 230 (Kelleher).

The Employer goes on to argue that in those cases where a monetary award has been found to be appropriate, it is usual for the award to be a small amount to reflect a loss of an opportunity to consult. In that regard monetary awards in those circumstances range from approximately $500.00 to $1,000.00: *Quintette Operating Corp. v United Steelworkers of America* (1997) B.C.C.A.A.A. No. 432 (Korbin) ($500.00); *Southern Railway of British Columbia v Canadian Union of Public Employees, Local 7000* (2015) B.C.C.A.A.A. No. 124 (Moore) ($750.00); *Re Burrard Yarrows Corporation, Vancouver Division and International Brotherhood of Painters, Local 138* (1981) B.C.C.A.A.A. No. 20 (Christie) ($750.00); *Avenor Inc v Pulp, Paper & Woodworkers of Canada, Local No. 11* (1997) B.C.C.A.A.A. No. 693 (Korbin) ($1,000.00).

The Employer submits that in one case where significant damages were awarded, the arbitrator found that the employer had failed to notify the union of its intention to contract out work valued at about $35,000.00. In all the circumstances of that case, the arbitrator ordered the employer to pay that amount to the union to encourage the employer not to breach its obligations in the future: *Howe Sound Pulp and Paper Ltd. v Unifor, Local 1119* (2014) B.C.C.A.A.A. No. 22 (Hall).

The Employer says it is not aware of any cases involving the duty to consult in respect to an employee's treating physician. Rather, the cases all involve an obligation on an employer to consult with the Union prior to a decision being made and action taken.

Individual Grievors

MW

The Employer argues that MW was treated respectfully by OHD medical staff including in her examination by Dr. Gablraith. Her personal medical information was not inappropriately or improperly shared and she is not entitled to the eight days of DIP benefits for which she not paid.

SR

The Employer says that SR did not object to a medical examination by Dr. Galbraith. Dr. Galbraith conducted the examination as part of the medical assessment requested by Dr. Mills and there is no breach of SR's privacy rights established.

The Employer submits that the Union's complaint in respect to SR largely focuses on SR's manager and is unrelated to the OHD.

The Employer goes on to say that the Union's claim for punitive damages is without any merit and is far removed from the high-handed, malicious, reprehensible misconduct necessary to justify such an award: see *Whiten v Pilot Insurance Co.* (2002) SCC 18 at para 94.

AD

The Employer submits that AD declined to attend an appointment with the OHD physician and there were no consequences for that. Accordingly, there can be no breach of the Collective Agreement found and in those circumstances, an award of damages would not be appropriate.

The Employer goes on to say that if a breach of the Collective Agreement is somehow established, the appropriate remedy would be a declaration.

Analysis and Decision

Privacy- Legal Framework

There is no real dispute between the parties regarding the arbitral jurisprudence in the area of employee privacy rights, which is fully canvassed in *Telus* and *West Vancouver.* While I accept and rely upon the general principles discussed in both of those decisions, I find it is only necessary to summarize the broad principles for the purposes of providing some context for my decision.

To begin with, arbitrators recognize employee privacy rights as being a fundamental value underlying the *Canadian Charter of Rights and Freedoms:* see for example *Telus* at para 76. In that context, the doctor-patient relationship is viewed as being one of the most private and the established arbitral view is that employee medical information beyond that which is reasonably necessary should not be disclosed: *Telus* at para 77.

It is well established that an employer's right to require an employee to be examined by a physician of the employer's choice and to have medical information disclosed to the employer, is not captured as a reserved management right. Rather, that right must be found in the express language of a collective agreement.

While employee privacy rights are important, they are not absolute.

The legitimate business interests of an employer are to be balanced with employee privacy rights and generally speaking, an employer is obliged to adopt the least intrusive means available to secure reasonably necessary medical information: *Telus* and *West Vancouver.*

An employer has a right to inquire into an employee's absence and an employee has an obligation to provide sufficient information to account for the absence. An employer is entitled to medical information that is reasonably necessary. What is necessary will depend on the circumstances of a particular case and the stage in the process.

The application of those general principles in this case should be informed by its context and circumstances.

Application to the circumstances of this case

As a general statement, the Employer has the right to ensure that employees are only absent from work for legitimate reasons. If an employee who is absent due to illness or injury is able to perform their duties in a manner that does not impede, undermine or jeopardize their recovery, the employee should return to work.

In my view, the Employer and Union share an interest in that regard.

As a general statement, as reflected in the Collective Agreement (22-LU-#1), the parties place considerable importance and value on the role of the OHD, particularly in accommodation and return to work areas, as is reflected in its role in the Joint Medical Placement Committee. A fundamental purpose of that committee is to facilitate the return to work and accommodation of ill or injured employees.

The competing interests in this case involve the Union's interest in protecting the privacy of its members and the associated right to be free from an unreasonable invasion or impingement of those rights by the Employer. The Employer's interest is in ensuring that it is able to manage employee absences and ensure that employees who are injured or ill are returned to work as early and safely as possible and that it has the information that is reasonably necessary for that to properly occur.

The essence of the Union's position is that the appropriate role of the OHD medical professionals in the context of the DIP beyond reviewing information provided by an employee's treating physician, is a very limited one and the involvement by the OHD physician should only occur as a matter of last resort.

More specifically, the Union says that the following steps are required by a proper application of the generally accepted privacy principles. In that regard, the OHD determination regarding an employee's eligibility for DIP benefits must be based only on the information provided by the employee's treating physician. If there is a reasonable basis for doubting the accuracy or truth of that information, the OHD may request further information from the employee's treating physician. If there is a reasonable basis to believe that the additional information provided is unreliable or insufficient, the employee should be referred to a specialist of the employee's choice. If having done that, a reasonable basis for uncertainty remains, the employee could then be required to see a physician of the parties' mutual agreement.

If a legitimate question remains, it is only at that point that the employee may be examined by the OHD physician.

A basic assumption of the employment relationship is that employees provide services in exchange for the payment of wages and benefits by an employer. Where an employee is unable to provide those services as a result of illness or injury, the employer's obligation to pay wages is, in effect, suspended.

These parties have negotiated a comprehensive scheme to ensure a continuity of earnings for employees who are unable to work due to non-work related illness or injury. Part of that scheme is the eligibility requirements in the Collective Agreement for the receipt of DIP benefits.

To establish eligibility, Article 37.02 requires that employees who are absent due to illness or injury and who wish to avail themselves of DIP benefits, must visit a physician of their choice to have the Physician's Report completed and forwarded to the OHD.

It is evident that the parties have agreed that the OHD is to be the means by which medical information that is relevant and necessary for the DIP process is to be received and maintained.

Once an employee's DIP application is approved, Article 37.09 (a) provides that the DIP benefits may be ended where the OHD determines, in consultation with the employee's physician, that the employee is no longer disabled. Article 37.09 (i) contemplates that an employee's treating physician may develop a treatment or rehabilitation plan in consultation with

the OHD and the employee's failure to abide by that plan may result in the termination of DIP benefits.

Article 37.10 (a) which provides that the Employer has a right to have an employee examined by a physician of the Employer's choice, does not identify any pre-requisites or place any conditions on the exercise of that right. That provision does expressly contemplate a consultative process with the employee's treating physician; however, the ultimate decision regarding whether an employee is disabled is to be made by the OHD. That decision is final.

In *Telus,* the collective agreement in that case provided that the employer could require a medical examination by a physician of its choice. Arbitrator Lanyon found that that language gave the employer the right to have an employee attend an IME with a physician of the employer's choosing. However, he also found that even with that language it was still necessary to determine under what circumstances the employer had the ability to exercise that right.

Arbitrators have found that the medical information that may be legitimately sought by an employer will depend on a number of factors including the stage of the process.

The essence of the issue arising in this case can be characterized as involving the appropriate role for the OHD in obtaining medical information beyond that provided by the employee's treating physician, either through referrals to specialists or medical examinations conducted by OHD physicians.

It is apparent that the OHD provides a number of health services for RTA employees which it has done for at least three decades. There is no real dispute, and in any event I am satisfied, that the OHD's role and practices have remained largely the same, and have been known and unchallenged by the Union over that period of time.

I note that Kitimat is a small, isolated community lacking easy access to a number of medical and support services such as, for example, medical specialists and drug and alcohol counselling services.

It is well known that occupational health is a specialist branch of medicine that focuses on the physical and mental well- being of employees. It also has a focus on the return to work of employees. I accept that the central role of the OHD in the context of the DIP is the return to work of employees and the assessment of and recommendations relating to adjustments to job duties that are designed to facilitate an early, safe return to work.

The Employer is entitled to sufficient information necessary to facilitate the early, safe return to work of injured or ill employees.

I am satisfied that Dr. Galbraith is a specialist in occupational health medicine, as is reflected in her qualifications. The specialization of the OHD medical staff is also reflected in the specialized training and knowledge possessed by Ms. Martins as an occupational health nurse. I accept that that specialized knowledge, which includes the job duties at the smelter and the specific operation of the workplace, would not be possessed by family physicians in Kitimat.

I am also satisfied that appropriate assessments by the OHD occupational health specialists can bring real value to questions involving an employee's ability to return to work or appropriate accommodation measures.

I find that the employees' treating physician have an ongoing relationship with their patients and provide a diagnosis in respect to ill or injured employees, assess the level of impairment and provide treatment to them.

As is apparent by the evidence of Dr. Mills and Dr. Galbraith, family physicians in Kitimat recognize the specialized expertise of the OHD medical staff and there is a productive professional relationship between family physicians and OHD physicians. That conclusion is reinforced by Dr. Mills' evidence acknowledging Dr. Galbraith's specialized expertise and that she is seen as a valuable resource in ensuring the safe return to work of ill or injured employees.

I accept Dr. Galbraith's and Ms. Martins' evidence to the effect that return to work and impairment or restriction assessments are a central or critical function of the OHD in the context of employees receiving DIP benefits.

I am satisfied that, in simplistic terms, in the context of the DIP, the primary role of the treating physician is to provide a diagnosis and treatment and to identify an employee's medical restrictions. I am satisfied that the primary role of the OHD medical staff is related to how the identified medical restrictions may be accommodated and whether or how the ill or injured employee can be safely returned to work at the smelter.

There should be no real doubt, and in any event I am satisfied, that an OHD physician and an employee examined by the OHD physician, have a doctor-patient relationship albeit an unusual one in that the OHD physician is also employed by RTA. That circumstance would presumably be the norm in the context of OHDs generally.

I am satisfied that the professional ethical considerations binding physicians (and nurses) generally apply equally to the OHD physicians, as they do to all occupational health physicians. In that regard, it is well established that as a professional ethical matter, occupational health physicians are expected to act as impartial professionals with an ethical duty to put the interest of the patient over those of their employer. Consistent with the generally well-understood ethical obligations on medical professionals, confidential medical information is to be protected and kept private. I find those same obligations apply to the OHD.

I am not prepared to conclude that simply because the OHD medical professionals are employed by RTA that they are in any way operating contrary to their professional ethical obligations, including not observing their primary ethical obligation to the medical professional/patient relationship.

There is no real dispute that it is appropriate for the OHD to receive the medical information contained in the Physician's Report which includes confidential employee medical information including diagnosis and treatment information beyond what an employer would normally be entitled to.

There is also no real dispute that it is appropriate for the OHD to seek additional confidential medical information relating to the information contained in the Physician's Report from the employee's treating physician.

I am satisfied that the OHD staff, not RTA managers, speak with the employee's treating physician if more medical information is found by the OHD to be necessary. In my view, that effectively eliminates the concern that confidential employee information may be inadvertently

disclosed to RTA management through any direct communication with an employee's treating physician.

In my view, that framework suggests an agreement between the parties which includes a recognized special role of the OHD, particularly in fitness to work and accommodation areas. A reasonably drawn inference would be that the parties' have understood that in the context of Article 37 of the Collective Agreement, the OHD would operate on an arms-length basis from RTA and ensure that the employee confidential medical information which is appropriately possessed by the OHD, would be protected and kept confidential.

I find that employee medical information received by the OHD is carefully stored, kept private and only accessed by the OHD medical staff. I am also satisfied that, as a general matter, the OHD does not release confidential employee medical information to RTA management including in respect to an employee's diagnosis or treatment, which would in my view, be inappropriate as that is confidential medical information. I am satisfied that the medical information released by the OHD to RTA managers is limited to that which is reasonably necessary to facilitate the accommodation or the successful return to work by an ill or injured employee.

I am also satisfied that OHD staff do not release confidential medical information to RTA human resources staff in the context of any disciplinary issues or proceedings, which would also in my view be inappropriate.

As noted earlier, Article 37 of the Collective Agreement provides the basis for the establishment of eligibility for DIP benefits and there is no dispute that the Employer has the right to make that eligibility determination.

Article 37.10 (a) gives the Employer the right to refer an employee to a physician of its choosing and there is no real dispute that generally means the OHD physician as has been the practice for more than 30 years.

I find that that right of referral is not unfettered and must be approached in the context of the importance of employee privacy rights reflected in all the circumstances of this case.

In my view, Article 37 contemplates a collaborative professional relationship between an employee's treating physician and the OHD physician. That is understandable given that such collaboration and consultation could be useful in ensuring an employee's early, safe return to work or accommodation.

I am satisfied that the vast majority of DIP claims are accepted by the OHD based on the information contained in the Physician's Report. That is consistent with the notion that the decision be made based on the information provided by the employee's treating physician unless that information is insufficient or inadequate in some way.

I accept that OHD physicians only see a small number of ill or injured employees and the decision to have an employee seen by OHD medical professionals is unusual and does not occur as a matter of course. I am satisfied those decisions are made on a case by case basis.

Accordingly, the issue arising is essentially whether, in the relatively small number of cases in which employees in receipt of DIP benefits are seen by OHD physicians, the OHD acts improperly vis a vis employee privacy rights or in a manner inconsistent with the Collective Agreement.

I am satisfied that the decision by the OHD to schedule an appointment is often the result of a treating physician couching a medical restriction in terms of an accommodation. That means that the information provided by the treating physician requires clarification.

In my view, some form of follow-up in those circumstances is not unreasonable nor does it constitute an unreasonable intrusion into employee privacy rights.

I find that where the information provided by the employee's treating physician is sufficient or does not raise legitimate questions or concerns, there would be no need for a referral to the OHD physician. I am satisfied that is reflected in the OHD practices and policies.

I also find that where clarification is reasonably necessary, the first step should be for the OHD to seek clarification from the treating physician. That would also in fact appear to be reflected in the existing OHD policies and practices.

The Employer has a right to reasonably assure itself that ill or injured employees are fit to safely return to work. The Employer also has an obligation to take steps necessary to determine the kinds of job modifications, restrictions or accommodations that could be put in place to allow an employee to safely and productively return to work so as to satisfy the Employer's accommodation obligations. It should not be a matter of any real controversy, and in any event I am satisfied, that the Employer has a legitimate interest in more detailed medical information, including otherwise confidential medical information, in cases involving a return to work or accommodation. In that context the duty to accommodate an employee necessarily requires the OHD to communicate with the employee, keep up to date with the employee's medical status and, on an ongoing basis, assess possible accommodation measures.

I note that, depending on the circumstances, in that context it may be appropriate for an employer to, for example, refer an employee to an occupational health physician chosen by the employer in order to assess the employee's ability to return to work through tests such as a Functional Capacity Evaluation: see for example *Telus* at para 85.

I pause to note that in this case both Dr. Galbraith and Dr. Davis are occupational health physicians.

I find that the issue of medical examinations by the OHD physicians in this case arises in the context of return to work and accommodation in which the Employer has a legitimate interest in a broader sphere of medical information. Having said that, the Employer is only entitled to confidential medical information necessary for those legitimate return to work and accommodation purposes.

It is apparent that OHD physicians will see ill or injured employees in the context of a return to work or accommodation assessment which may be the result of a request originating with the employee's treating physician or the employee themselves.

I am satisfied that an appointment and examination in those circumstances cannot reasonably be found to constitute a violation of employee privacy rights.

I am not satisfied that referrals to the OHD by RTA managers are typically the result of managers questioning the legitimacy of DIP claims resulting in an assessment being made by the OHD physician for that purpose.

However, I am satisfied that from time to time, an RTA manager may refer an employee to the OHD. I accept that such a request typically will be in the context of a workplace injury or where a manager observes or becomes aware of possible difficulties or issues in terms of the employee's accommodation. I am satisfied the purpose of such a referral is, in the case of an injured employee, for the OHD to assess the extent of the injuries, and in both circumstances, to assess the employee's fitness to work and possible modifications to an employee's duties. I accept that in those cases, RTA managers are only provided with information necessary to explain whether the employee is fit for work and to provide information necessary to facilitate a return to work or accommodation.

I am satisfied that in circumstances involving a workplace injury, as is reflected in the circumstances of AD's case, employees are typically given the choice of seeing either the OHD physician or their family physician.

I find a referral to the OHD in those situations is not inappropriate and does not constitute a violation of the employee's privacy rights under all the circumstances.

I note, and there is no real dispute, that the OHD is able to expedite referrals of ill or injured employees to medical specialists and other resources such as drug and alcohol services, for employees in receipt of DIP benefits. It should not be a matter of any real controversy that those expedited referrals, particularly to assist an employee's recovery and return to work, are of considerable benefit to all parties. In addition, those referrals (outside of the Employee and Family Assistance Program) are typically paid for by the Employer.

I am satisfied that such a referral would typically only be made where there are reasonable grounds for the OHD physician to believe that more information or a specialist opinion would be helpful, particularly in the return to work and accommodation assessments. I am satisfied, and as is disclosed on the evidence, the employee's consent for such a referral is typically required. I am also satisfied that the employee's treating physician is typically part of that process. That conclusion is buttressed by the circumstances of SR's case.

In my view, a referral in those circumstances would not be inconsistent with the least intrusive principle and would not constitute an unreasonable intrusion into employee privacy rights.

I accept Dr. Galbraith's evidence that in such cases, where the employee has consented to a referral to a specialist, as the referring physician, she finds it medically useful to examine the employee herself in order to be able to provide a reasonable amount of information in the referral letter to the specialist. I am satisfied there is a reasonable basis for such an examination and it does not, as a general matter, constitute an unreasonable intrusion into employee privacy rights, particularly given the employee's agreement to such an examination and referral.

I also accept that the specialist report is provided to the referring physician, which in those cases would be the OHD physician, and that the report is then forwarded to the employee's treating physician.

I accept Dr. Galbraith's evidence to the effect that, as the referring physician, the OHD physician has a professional obligation to follow-up the report with the employee. Accordingly, I accept there is a legitimate medical reason for such a follow-up visit and I am satisfied it does not constitute an unreasonable intrusion into employee privacy rights.

I find that follow up appointments involving an employee and the OHD physician do not occur as a matter of course. They typically occur following a referral to a specialist by the OHD or in the context of a graduated return to work, to assess an employee's progress and medical restrictions impacting their ability to perform their job duties at the smelter. Appointments in the latter cases are generally initiated through the OHD nurse.

In my view, there is a distinction between a situation where a medical examination is sought by the OHD where it has reasonable questions regarding an employee's fitness to return to work or what appropriate accommodation measures should be put in place and where the veracity of the medical information (for example relating to a diagnosis or course of treatment) provided by the treating physician is questioned or challenged.

While the Employer has a wider sphere regarding medical examinations in the context of a return to work and accommodation areas, it is not unrestricted. As noted by Arbitrator Lanyon in *Telus*, in that context, the Employer is not entitled to make open-ended inquiries. As he put it:

> *……the employer is entitled only to the specific information required to make its determination….the employer is not entitled to "impose additional requirements with respect to medical examinations or certificates"…For example, if the injury concerns an employee's back, the employer is not entitled to that employee's psychiatric or sexual history. Perhaps this is simply another way of stating that the employer is only entitled to that information which is reasonably necessary* (para 86).

I accept Dr. Galbraith's evidence that, as a general matter, OHD medical staff are very careful not to make open-ended medical inquiries. I am satisfied that the medical information sought, including in medical examinations of employees conducted by the OHD, is specific and for a specific purpose. I am satisfied the examination by the OHD physician focuses on issues arising from the Physician's Report in the context of return to work and accommodation assessments. I am also satisfied that if the OHD concludes more medical information is necessary, the OHD requests that the employee provide their consent before further information is sought.

I note that where the Employer has a legitimate interest in obtaining additional medical information relating to an employee's ability to return to work or appropriate accommodation measures, its release will generally require the employee's consent. Where legitimate questions exist and the requirement for consent is reasonable, an employee who refuses to provide it may suffer certain consequences, but not discipline, which may include a refusal by the Employer to allow a return to work or the suspension or even termination of DIP benefits.

I am satisfied that as a general matter, while there may well be some overlap between the role of the treating physician and the OHD physician, the latter is not typically involved in the diagnosis and treatment of an employee. Rather their focus is on return to work and accommodation assessments.

I accept that, while the fitness to work assessments by an OHD physician are typically accepted by RTA management, the OHD physicians are not part of the administrative decision making regarding whether DIP benefits should be suspended or terminated. That decision is made by RTA management based on a determination by the OHD physician regarding whether the employee is disabled.

Article 37.02 (a) expressly contemplates that the OHD physician will consult with an employee's treating physician. That reflects the collaborative nature of the relationship between those physicians which the parties have recognized and which could also potentially assist in the early, safe return to work of employees in some cases.

Dr. Galbraith was candid in her evidence both that she was unaware of the obligation to consult under Article 37.02 (a) as well as that it was not her general practice to consult with the employee's treating physician before a disability determination was made. She said that she was particularly conscious of the fact that family physicians in Kitimat tend to be very busy, often seeing 50 to 60 patients a day, and that regular, constant contact by OHD staff would impose an unreasonable burden on the family physicians.

Notwithstanding those practical considerations, the Employer indicated that OHD physicians will in future consult with employees' treating physicians.

I am satisfied that, as is reflected in Ms. Martin's evidence, when an OHD nurse contacts an employee to arrange an appointment with an OHD physician, typically, the purpose of the call is explained and the employee is offered an opportunity for an appointment with an OHD physician.

I accept that, while it would be reasonable to infer that employees would generally be aware that a medical examination by an OHD physician would be part of the DIP process, where an employee agrees to an appointment, OHD physicians typically only explain the reason for the medical examination to the employee if it is readily apparent that the employee is unware or confused about the purpose of the appointment.

Finally, I also find that it is likely that the role of the OHD physician is not typically explained to the employee, unless it is very apparent that the employee is unaware or confused about the role of the OHD physician.

Individual grievances

MW

I begin by noting that MW had been accommodated by the Employer for a significant period of time. Part of the duty to accommodate necessarily involved the OHD communicating with MW, keeping up to date with her medical status and assessing possible accommodation measures on an ongoing basis.

MW was unable to continue to work in February 2016, even with the accommodations that were in place.

The March 17, 2016 Physician's Report received by the OHD in respect to MW simply indicated the diagnosis as being "elbow". I am satisfied the purpose of the follow-up by the OHD was to clarify the diagnosis and for Dr. Galbraith, in the context of MW's long-standing accommodation, to assess both MW's fitness to return to work and whether an accommodation was appropriate or whether additional job modifications might facilitate a return to work. Dr. Lacaille's report was requested to assist in that assessment and I am satisfied MW consented to having that report provided to the OHD.

I am satisfied that the anonymous tip relating to MW's alleged babysitting of a two year old child while also in receipt of DIP benefits, played no role in the OHD decision to have MW seen by Dr. Galbraith. I am satisfied that that decision was made for medical reasons unrelated to labour relations or any other non-medical considerations.

I am satisfied that the concerns expressed in the anonymous tip played no part in Dr. Galbraith's assessment of MW's fitness to return to work.

There is no dispute that in her report, Dr. Lacaille did not provide any opinion regarding MW's fitness to return to work nor did she indicate her view as being that MW should remain off work for a month. I am satisfied that Dr. Galbraith in her role as an occupational health specialist, examined MW's range of motion in her shoulders, arms, wrists and hands in the context of making a medical assessment regarding MW's fitness to return to work in her administrative job at the smelter and to determine any possible or necessary accommodation measures. I am satisfied that assessment was clearly linked to the accommodation process.

I find the inquiries made during that examination of MW were specific, relating to a specific purpose, designed to assess MW's fitness to return to work and any necessary accommodations. I find the inquiries were not open-ended. I am satisfied that Dr. Galbraith did not gather more information that was reasonably necessary for the purposes of the fitness to work and accommodation assessments.

Dr. Galbraith concluded that MW was fit to return to work with the same temporary restrictions as had previously been in place.

I am satisfied that the OHD had no involvement in the decision as to where MW was placed on her return to work.

As previously noted, Article 37.10 expressly gives the OHD the final decision in fitness to work assessments. Dr. Galbraith examined MW, considered Dr. Lacaille's report and concluded that MW was fit to return to work with certain restrictions in place. I am satisfied that on April 5, 2016, Dr. Galbraith advised MW that she was fit to attempt a graduated return to work and encouraged MW to discuss Dr. Galbraith's proposed accommodation measures with MW's physician. However, MW did not do so until April 14, 2016 at which time MW's physician agreed with Dr. Galbraith's conclusion that MW was fit to return to work on the basis of the restrictions proposed by Dr. Galbraith.

I find that the failure to consult with MW's treating physician (and Dr. Lacaille) does not void Dr. Galbraith's opinion regarding MW's fitness to return to work with restrictions. Accordingly, I find there was a legitimate basis for the Employer's decision to suspend MW's DIP benefits for the eight days.

I find there is no basis established upon which I can reasonably conclude that MW's privacy rights were unreasonably impinged by the OHD.

While I accept that the OHD decision regarding fitness to return to work is final, I am also satisfied that Dr. Galbraith did not consult with MW's physicians prior to making the determination that MW was fit to return to work as is contemplated under Article 37.02 (bearing in mind that MW's family physician agreed with Dr. Galbraith's assessment).

SR

It is apparent that SR was very concerned about the requirement that he work mandatory overtime in 2015-2016, which led to conflict with RTA management, including an altercation with his manager, which resulted in SR being disciplined.

It is also apparent that in his November 27, 2015 appointment with SR, Dr. Mills concluded that while he was unable to ascertain the source of SR's anxiety, the workplace dynamic was contributing to both it and SR's hypertension. Dr. Mills' report indicated a medical restriction as being that SR should be excused from being required to work mandatory overtime.

It is also apparent that in early January 2016, RTA management initiated a request that SR be seen by an OHD physician.

An appointment was scheduled for SR with the OHD on January 12, 2016, which SR declined to attend. He chose to see Dr. Mills on January 12 instead.

In his report on January 25, 2016, Dr. Mills found that SR was not fit to work. That opinion was confirmed in Dr. Mills' report of February 25, 2016.

OHD staff left several messages in January and February, 2016 with SR, but those calls were not returned.

Dr. Mills wrote to Dr. Galbraith on March 2, 2016 providing more information regarding his diagnosis and opining that SR's manger should not approach SR, going on to request Dr. Galbraith's comments. On receipt of that letter, Dr. Galbraith unsuccessfully attempted to contact Dr. Mills. She then made several unsuccessful attempts to contact Dr. Mills over the next several weeks until she was ultimately able to speak with him on March 23, 2016.

On the evidence, it is apparent that Dr. Mills and Dr. Galbraith have a long-standing, productive professional relationship.

I accept that the reason Dr. Galbraith wanted to speak with Dr. Mills was because he had asked for her input. I also accept that Dr. Galbraith wanted to clarify aspects of Dr. Mills' report particularly because she needed more information regarding SR's medical condition. That included information relating to SR's anxiety, such as information regarding its nature and source, which could have impacted a return to work plan. I also note that in his letter of March 2, 2016, Dr. Mills had noted that SR had passed out while driving his vehicle, expressing serious concerns about SR's ability to drive his personal vehicle. That would have raised a legitimate concern regarding his ability to operate a vehicle or equipment at work.

Under all the circumstances, I am satisfied that Dr. Galbraith had legitimate reasons for attempting to speak with Dr. Mills regarding SR's medical circumstances.

I also accept that, on receipt of Dr. Mills' March 2, 2016 letter, Dr. Galbraith immediately wrote an email to RTA managers advising that SR was being treated by Dr. Mills, that Dr. Galbraith did not have a signed consent to speak with Dr. Mills to clarify SR's medical issues and that SR was not fit to return to work at that time. She also noted that SR was unable to attend work to meet with RTA managers.

Earlier that same day, Ms. Martins had written to RTA managers advising that SR's manager should not contact SR. I am satisfied that neither Dr. Galbraith nor Ms. Martins encouraged or advised SR's manager to contact SR, and in fact, did the opposite.

I am also satisfied that Dr. Galbraith communicated to RTA managers that her role in respect to SR was to focus only on medical issues relating to whether SR was fit to return to work.

I find that Dr. Galbraith felt constrained about speaking with Dr. Mills until she had received a signed consent from SR, which she ultimately did on March 18, 2016. In my view, that highlights the care taken by the OHD in respect to the disclosure of employee confidential medical information.

I find that when Dr. Mills and Dr. Galbraith were able to speak on March 23, 2016, they agreed on steps to be taken to assist SR, including that Dr. Galbraith would facilitate an expedited referral to Dr. Buchanan.

I am satisfied that SR subsequently agreed to an appointment with Dr. Galbraith and in that appointment they discussed the referral to Dr. Buchanan, which SR agreed to. I find that as part of that referral process, Dr. Galbraith reasonably found it necessary, as the referring physician, and with SR's consent, to herself examine SR in order to provide useful and fulsome information to Dr. Buchanan in her referral letter.

I accept Dr. Galbraith's evidence that, as the referring physician, she would receive Dr. Buchanan's IME report and had an ethical obligation to at least attempt to follow-up with SR to discuss it. I accept that SR agreed to the follow-up visit with Dr. Galbraith for that purpose.

I find that there was a legitimate reason for Dr. Galbraith's involvement with SR which related in large measure to expediting the referral to Dr. Buchanan which Dr. Mills and SR both agreed to. I also accept that Dr. Galbraith also had a legitimate reason for the follow-up visit with SR, which he also agreed to.

I am satisfied that the OHD did not share any confidential medical information regarding SR with RTA managers beyond the fact he was not fit to return to work and certainly did not share information relating to his diagnosis or treatment, which would have been inappropriate.

I find that Dr. Galbraith provided Dr. Mills with input into SR's treatment plan. I accept Dr. Galbraith's evidence to the effect that that reflected the unique circumstances of SR's case, including the fact that Dr. Mills had asked for her input. I accept Dr. Galbraith's evidence to the effect that she saw her primary role as being the assessment of SR's medical restrictions, ability to return to work and any appropriate accommodation measures that might be put in place.

I am satisfied that while Dr. Galbraith facilitated SR's referral to Dr. Buchanan and participated to some extent in his treatment plan, her primary focus in respect to SR was to assess his fitness to return to work and any possible accommodation measures that might have been appropriate but not to diagnose and treat SR. Rather her role was to have Dr. Mills' diagnosis clarified in order to properly assess SR's ability to return to work.

Finally, I find the subsequent appointments with OHD medical staff were all for the purpose of assessing both SR's fitness to return to work and any possible accommodations, particularly in the context of the ongoing medical tests that he was undergoing.

I find the OHD did not gather more medical information than was reasonably necessary and did not unduly intrude into SR's privacy rights. I find the conduct of the OHD is not inconsistent with the "least intrusive measures" principle particularly when viewed in all the circumstances.

AD

I am satisfied it is not unusual at the smelter that where an employee is injured at work, a referral to an OHD physician is made by the employee's supervisor or manager in order to have the OHD physician assess the extent of the injury and the employee's fitness to work.

Consistent with that practice, following AD's injury at work on November 13, 2105, his supervisor contacted the OHD to request that AD be seen by Dr. Galbraith. An appointment was made for AD; however, it is apparent that the RTA Safety Co-ordinator later cancelled it on November 24, 2015. I find that the purpose of that appointment was for Dr. Galbraith to assess the extent of AD's injury and his fitness to return to work. In any event, AD was not required to and did not attend any appointment with the OHD.

I note that given the OHD physicians' specialized knowledge of occupational health medicine and the smelter operations and the fact the OHD is physically located in the plant, a referral to the OHD physician would be a convenient means of providing an expeditious specialist assessment regarding an injured employee's fitness to work.

There is no evidence that AD, or any other injured employee has, in the absence of their consent, been required to attend an appointment with the OHD physician following a workplace injury.

Following AD's return to work on modified duties he subsequently independently approached the OHD and requested information relating to his accommodation and, at that point with his agreement, an appointment was made with Dr. Galbraith for that purpose. AD subsequently cancelled that appointment, preferring to see his family physician instead. I accept that AD would have been happy to have seen Dr. Galbraith if his family physician had not been available.

The Employer never required AD to be examined by an OHD physician in the absence of his consent and provided him with the choice of seeing either his family physician or the OHD physician.

I am satisfied that the OHD did not in any way "pursue" AD for an appointment. I am also satisfied that there is no basis upon which to reasonably conclude the referral of AD to an appointment with Dr. Galbraith was a breach of the Collective Agreement..

In summary, I find that the OHD plays an important role in ensuring employee health and safety at RTA. The importance placed on it by the parties, particularly in fitness and accommodation areas, is reflected in its role on the Joint Medical Placement Committee as is contemplated under #22-LU-#1 of the Collective Agreement.

The parties have agreed that the OHD has a legitimate role in the development of a treatment or rehabilitation program or plan by an employee's treating physician.

As a general comment, in the circumstances of this case, the role of an employee's treating physician is to diagnose and treat an ill or injured employee. The role of the OHD medical professional staff in the context of DIP cases is primarily to assess how identified medical restrictions can be accommodated and whether an ill or injured employee can be safely returned to work.

Medical information supporting a DIP claim is provided to the OHD by the treating physician and the OHD only shares with RTA managers the information that is reasonably necessary to alert managers that the employee is not fit to return to work and to facilitate a successful return to work or accommodation.

The vast majority of DIP claims are approved based on the information provided by the employee's treating physician and an examination by the OHD physician is not, nor should it be, typical or a matter of course. Where a Physician's Report lacks clarity, the typical first step by the OHD is to ask the treating physician for clarification or additional information.

The role of the OHD physician is to provide neutral, objective assessments of employees' ability to return to work or be accommodated.

A typical reason for an appointment to be scheduled for an employee with an OHD physician is where an employee's treating physician couches a medical restriction in terms of an accommodation.

The OHD physician sees employees in order to assess either their fitness to return to work or accommodation measures. A referral for that purpose may originate with an employee's treating physician or the employee themselves.

As well, RTA managers from time to time, refer employees to the OHD. That typically occurs where an employee has suffered a workplace injury or issues with their accommodation are noted.

Any referral from human resources or labour relations staff to the OHD is, and should be, rare.

Appointments with the OHD physicians may also be scheduled in order to facilitate referrals to medical specialists. Such referrals occur with the consent of the employee and it would appear typically also with the agreement or understanding of the employee's treating physician. In those circumstances, the OHD physician legitimately conducts an examination of the employee for the purposes of providing useful and fulsome information in their referral letter to the specialist.

In their examinations of employees, OHD physicians do not typically make open-ended inquiries. The information sought relates to that contained in the Physician's Report and is specific and for a specific purpose.

Where OHD physicians refer an employee to a specialist, the OHD physician will typically, as the referring physician, receive a copy of the specialist's report. The OHD physician will typically, with the employee's consent, provide the report to the employee's treating physician. As the referring physician, the OHD will typically schedule a follow-up visit with the employee to discuss the contents of the report.

I am satisfied that the practices and policies of the OHD do not cause or result in an unreasonable intrusion on employee privacy rights. Accordingly, that aspect of the Union's policy grievance is denied.

On the evidence, I also find that the OHD did not unreasonably intrude onto the privacy rights of the three individual grievors. Accordingly, that aspect of the Union's grievance is denied.

It would appear that employees seen by the OHD physician may not always completely understand the role of the OHD and the reason for an appointment. In my view, it would be reasonable to expect that where an appointment with the OHD is appropriate, its purpose and the role of the OHD would be explained as a matter of course. As well, where an employee is examined by an OHD physician, the physician's role would be explained. That explanation could include advising that the OHD physician is not the employee's treating physician and of the nature of the OHD physician's role vis a vis return to work and accommodation.

There is one remaining issue arising from the Union's grievances relating to the obligation on the OHD to consult with an employee's treating physician prior to a determination being made regarding whether the employee is disabled.

An injured or ill employee's treating physician typically has a long-standing relationship with the employee and an understanding of their medical history. The role of the treating physician is to provide a diagnosis and to treat the employee.

The focus of the OHD is on the return to work and accommodation of ill or injured employees using the specialized occupational health medicine expertise of the OHD medical staff.

Working together through a consultative framework is a means of potentially assisting in the early, safe return to work of ill or injured employees.

I find, and the Employer concedes, that the practice of the OHD has not been to consult with an employee's treating physician prior to making the determination of whether the employer is disabled or fit to return to work. In my view, while Article 37 provides the OHD with the right to make the final decision in that regard, the OHD practice has not been consistent with the obligation to consult contemplated in Article 37.

While I accept the practice has arisen for a variety of understandable reasons, including practical ones such as the busy schedules of family physicians in Kitimat and the potential burden and possible delay that frequent consultation by OHD staff may result in, that does not release the OHD from the obligation to consult, within the context of practical realities, including the circumstances of each case.

Remedy

As noted, the Union seeks damages both in respect to its policy grievance and the individual grievances as a result of the alleged breach of employee privacy rights.

In respect to the individual grievors, the Union seeks damages to compensate MW for the denial of eight days of DIP benefit payments as well as $10,000.00 for an alleged violation of her privacy rights.

The Union also seeks damages for SR in respect to an alleged violation of his privacy rights as well as damages in respect to his alleged mental distress and suffering, as well as punitive damages relating to the conduct of SR's manager.

Section 82 of the *Labour Relations Code* gives arbitrators the authority to award compensatory damages for a loss arising from a breach of a collective agreement.

Compensatory damages flow from the basic remedial principle that a party should be placed in the position they would have been but for the breach. They are intended to be compensatory, not punitive.

Punitive damages are available but only where compensatory damages are found not to be sufficient. To be available, there must be an independent actionable cause and it must be found that the wrongdoer's misconduct is so egregious, reprehensible or malicious that it offends a sense of decency.

Punitive damages have no relation to what should be received as compensation. Rather, their aim is to punish clearly egregious conduct and are only available where damages and aggravated damages are insufficient so as to warrant damages for the purposes of deterrence, and denunciation: see for example *Hill v Church of Scientology of Toronto* (1995) 2 SCR 1130 (SCC).

Given my conclusion that the Employer did not improperly suspend MW's DIP benefits for eight days, no compensatory remedy arises.

As well, in light of my conclusion that there was no breach of employee privacy rights, no remedy for compensatory damages arises in that regard.

I note that the Union's express concern in its grievance relates to the policy and operation of the OHD. Given my conclusion that the OHD played no role in the actions of SR's manager, there is no basis upon which to reasonably conclude the OHD did anything at all to contribute to any alleged mental distress suffered by SR. Even if I was persuaded that the OHD should be held accountable for the conduct of SR's manager, I would find that the circumstances are far removed from the egregious and extraordinary circumstances required for such a remedy to be provided.

Having reached those conclusions, I have found that the OHD practices do not comply with the consultative obligation in Article 37 of the Collective Agreement.

In my view, while the obligation to consult with an employee's treating physician prior to determining an employee is disabled would not likely arise as a practical matter in the vast majority of cases; i.e. where DIP claims are approved on the basis of the information provided by an employee's treating physician, it is nonetheless a negotiated right which should be given meaning and its full effect.

It is apparent that while the OHD has the final word, the parties have agreed that all necessary input and information should be available particularly in the determination regarding whether an employee is not, or is no longer disabled, on a case by case basis.

In my view, the failure to consult constitutes a "lost opportunity".

The general principle guiding a lost opportunity remedy is that, if a declaration is not sufficient, any damages awarded should be more than nominal and be sufficient to provide an employer with a meaningful incentive to ensure future compliance. I accept that the usual range for such awards is between $ 500.00 and $4,500.00 (the latter was awarded in *Re B.C. Rail v United Journeyman, Local 170* (2004) B.C.C.A.A.A. No. 288 (Munroe)).

While the Employer's commitment to ensure the OHD consults with employee treating physicians going forward is a factor to be weighed in determining an appropriate remedial response, I find a simple declaration is not sufficient and I find it to be appropriate to direct that the Employer pay the Union $ 1,000.00 to compensate for the lost opportunity associated with the OHD's general practice of not consulting with employee treating physicians before a determination that an employee is not or is no longer disabled is made.

Conclusion

For the reasons provided, I find the practices and policies relating to the operation of the OHD and its actual functioning, do not cause or result in an unreasonable intrusion on employee privacy rights. Accordingly, that aspect of the Union's policy grievance is denied.

For the reasons provided, I find the OHD did not unreasonably intrude into the privacy rights of MW and SR. Accordingly, that aspect of those grievances is also denied.

Also for the reasons provided, I find no violation of the Collective Agreement in respect to the Employer's decision to suspend MW's DIP payments for eight days.

For the reasons provided, I find that there is no basis established for an award of punitive damages in respect to SR. I also find there is no violation of the Collective Agreement in respect to AD and therefore no award for damages is appropriate.

Finally, for the reasons provided, I find that while Article 37.10 gives the OHD the right to make the final decision regarding an employee's fitness to work, the OHD practice has not been consistent with the obligation under Article 37 to consult with an employee's treating physician. Accordingly, I find that the Union's grievance should be granted in part in that regard.

I find an appropriate remedy to be an award of damages in the amount of $ 1,000.00.

I will retain jurisdiction to deal with any issues arising regarding the interpretation or application of this Award.

Dated in the City of Vancouver, this 17^{t} day of November, 2017

"MICHAEL FLEMING"
Arbitrator