ABVE CONFERENCE

DISABILITY INSURANCE – ISSUES AND TRENDS

The law's ambivalence toward disability issues and the US experience

In a 2011 article published in *American Journal of Law & Medicine* entitled Disability, Ambivalence, and the Law[1], the author argues that our society is highly ambivalent towards disability and this is reflected in our laws. Put simply, he argues that "Disability attracts because it is a force that makes us human and disability repels because it is a force that threatens our humanity." Mr. Muller argues that the law should reflect this ambivalence so as to more accurately and sensitively address the challenges that disability issues raise for society.

Even within the disability arena, a significant divide exists between physical illness and mental illness. While the *Patient Protection and Affordable Care Act* (ACA) mandates that insurers provide coverage for both physical and mental illnesses and the *Mental Health Parity and Addiction Equity Act of 2008* (MHPAEA) requires that mental health benefits be offered in parity with medical/surgical benefits, the same level of parity does not exist with most US disability insurance coverages, most of which cap or otherwise explicitly limit disability due to mental illness[2].

Ambivalence as to whether mental illness is a failure of will or a disease that requires treatment may explain a conflict in the US circuit courts regarding whether the risk of relapse into addiction can constitute a current disability under an ERISA-administered group of long-term disability benefit policy.

In ***Stanford v. Continental Cas. Co***., 514 F. 3d 354, 361 (4th Cir. 2008), the issue was whether Robert Stanford, a Certified Nurse Anesthetist (CRNA) who had become addicted to Fentanyl (a powerful opiate administered by anesthetists during surgery) was entitled to continue to receive disability benefits after his discharge from a third treatment program on the basis that he was no longer "functionally disabled". The evidence was that Mr. Stanford had relapsed after the first and second treatment programs and was at risk of a further relapse if he were to return to work as an anesthetist. This policy, like many others, had an "own occupation" period and an "any occupation" period. The termination of benefits had taken place during the "own occupation" period.

The Fourth Circuit ruled that a potential risk of further relapse did not constitute a disability and Mr. Stanford did not qualify for further benefits. The court distinguished cases where physicians had been found to be disabled because of the risk of recurrence of a heart attack, reasoning that an addict who enters an environment where drugs are readily available is not at risk of relapse except in the sense that the environment heightened the temptation to take drugs.

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[1] John F. Muller, "Disability, Ambivalence and the Law" (2011) 37 American Journal of Law & Medicine 469-521

[2] The Supreme Court of Canada determined in 1996 that a policy which discriminated against mental illness was a violation of the provincial Human Rights Code and referred the matter back to the employer for remedial action. Consequently, disability insurance policies written in Canada do not distinguish between disabilities arising from mental as opposed to physical illness. (see *Battlefords and District Co-operative Ltd. v. Gibbs* [1996] S.C.J. No. 55.

The facts in ***Colby v. Union Security Insurance Company & Management Company for Merrimack Anesthesia Associates Long Term Disability Plan***, 705 F. 3d 58 (1st Cir. 2013) are remarkably similar to those in *Standfard,* supra*.* Dr. Colby worked as a staff anesthesiologist at a hospital and also became addicted to Fentanyl. She underwent treatment where she was diagnosed with opioid dependence, major depression and obsessive compulsive personality traits. The insurer argued that Dr. Colby ceased to be disabled when she ceased to be addicted to opioids. The District Court noted that the insurer had failed to determine "whether the probability of Dr. Colby relapsing upon a return to the practice of medicine was so high that she could not perform a material duty of a physician", a consideration that was supported on appeal.

In the US, discrepancies also exist in relation to the enforcement of the duty to accommodate in an employment setting as compared to the enforcement of the duty to accommodate in the provisions of goods and services. In *Accidentally on Purpose: Intent in Disability Discrimination Law*[3], the author examines the challenges of proving intentional discrimination and differences in how the courts have enforced anti-discrimination legislation.

The US legislation governing employment discrimination is found in Title I of the *Americans with Disabilities Act* (ADA) which "requires employers to make reasonable accommodations to known physical or mental limitations of otherwise qualified individuals with disabilities unless the employer demonstrates undue hardship on the operation of its business. It further bans denying employment opportunities to otherwise qualified individuals with disabilities if the denial is based on the need to accommodate." (pp. 1426-1427)

Professor Weber noted that there was no requirement to prove intent in employment cases and lauded a system where the degree of liability generally matches the degree of damages:

> "With regard to ADA employment cases, the law thus creates a hierarchy of intent and corresponding remedies, with malice and reckless indifference at the top, then ordinary intent, then denial of reasonable accommodation without any showing as to state of mind, then disparate impact, then denial of reasonable accommodation with a demonstration of good faith effort by the defendant. Notably, everything that is a violation at all merits some monetary remedy such as back pay, as well as the whole range of injunctive remedies." (p. 1430)

He pointed out that when it comes to discrimination in goods and services (Title II and Section 504 Prohibitions), however, despite wording in the regulations forbidding actions that have discriminatory effects (i.e. irrespective of intent), courts have tied remedies to proving intent, a result which divorces the harm done from redress for such harm:

> "These disparate impact, reasonable modifications, and integrated services regulations implementing the ADA government services title and section 504 are based on the recognition that for persons with disabilities, what discriminates against them, what Congress was trying to

[3] Mark C. Weber, "Accidentally on Purpose: Intent in Disability Discrimination Law" (2015) 56 Boston College Law Review 1417

> change, is government activity and inactivity that prevents them from achieving equality in the enjoyment of public spaces, public schools, public health services, public transportation and the wealth of programs and facilities that modern government furnishes its citizens. That harm is no less real for being heedless." (p. 1435)

General legal principles of disability insurance

Fundamentally, disability insurance policies are purchased in order to provide individuals with a basic level of financial security if they become too ill to work. The courts have recognized the vulnerability of insureds following an insured loss and impose on insurers a duty of good faith.

As stated in ***Fidler v. Sun Life Assurance Co. of Canada,*** 2006 SCC 30:

> "The duty of good faith requires an insurer to deal with its insured's claim fairly. The duty to act fairly applies both to the manner in which the insurer investigates and assesses the claim and to the decision whether or not to pay the claim. In making a decision whether to refuse payment of a claim from its insured, an insurer must assess the merits of the claim in a balanced and reasonable manner. "

In ***Bhasin v. Hrynew***, 2014 SCC 71, the Supreme Court of Canada clarified that *all* contracts have an implied, fundamental duty of honest dealing. The law in Canada and most of the US is that good faith contractual performance is a fundamental component of all contract. In other words, parties to a contract are expected to act honestly in the performance of their contractual obligations.

What do disability policies say about rehabilitation?

The essence of a disability contract is financial: the insured assumes a legal obligation to pay insurance premiums and the insurer assumes a legal obligation to pay disability benefits in the event the insured becomes "totally disabled" as defined in the policy.

Rehabilitation issues are secondary to these fundamental financial obligations. However, if an insurer decides to introduce rehabilitation, the manner in which the rehabilitation support is provided and/or the manner in which an insured responds to a rehabilitation initiative can have significant implications for the parties.

Most policies do not explicitly distinguish between medical rehabilitation and vocational rehabilitation.

In terms of medical rehabilitation, essentially all policies require an insured to be under the care of a physician. Increasingly, policies are requiring insureds to comply with recommended medical treatment. Some policies go further and allow the insurer to either set up or approve a rehabilitation program that an insured would then be expected to pursue. There are grey areas regarding how much the insurer can direct an insured's medical care and if there was a conflict between what the insurer proposed and what the treating doctors recommended, it is likely that an insurer would not be able to override an insured's family physician or treating specialist.

In terms of vocational rehabilitation, most group disability insurance policies contain a provision that contemplates some type of vocational rehabilitation or support during a graduated return to work. These provisions usually:

- give the insurer complete discretion as to whether and in what manner it will fund rehabilitation support. This protects the insurer and allows it to conduct a cost benefit analysis of the proposed rehabilitation plan before agreeing to fund it. As a result, most proposals are limited in duration and cost; and
- provide an incentive to the insured to try to return to work, by allowing the insured to keep some or all their earnings and still be paid some or all of their benefits (up to a stipulated maximum), but only if the rehabilitation plan is pre-approved by the insurer.

Sometimes, a rehabilitation provision is given mandatory status. In such a case, a policy will state that benefits will terminate if the insured refuses to participate in a rehabilitation program approved by the insurer.

When do rehabilitation issues most often come into play?

The vast majority of group disability insurance policies have a one to two year "own occupation" period after which the policy definition for total disability changes to an "any occupation" test. During the own occupation period, an insured is considered totally disabled (and qualifies for disability benefits) if he/she is not able to work in their own occupation. During the any occupation period, the insured is considered to be disabled only if he/she is unable to work in any capacity for which they are suited by virtue of their education, training or experience. Some policies may include a monetary threshold – i.e. the insured is to be considered totally disabled if he/she is not able to earn 50% (or 60% or 70%) of their pre-disability earnings. The higher the threshold, the easier it is for the insured to qualify for benefits and vice versa.

Rehabilitation issues usually arise either during the own occupation period or as the parties approach the transition from own occupation to any occupation. Rehabilitation issues can also arise when there has been (or there is expected to be) an improvement in the insured's condition.

What are some of the issues that come up in a vocational rehabilitation setting?

Some of the more common issues that arise are:

a) whose opinions count in deciding whether a GRTW is appropriate and/or setting up a GRTW plan:

   (i) the insurer
   (ii) the insured
   (iii) the vocational consultant / rehabilitation specialist
   (iv) the insured's treating doctors
   (v) an IME expert

b) once a GRTW is put into place, what are the responsibilities of:

(i) the insurer
(ii) the insured
(iii) the vocational consultant / rehabilitation specialist
(iv) the employer

Interaction of disability insurance laws and employment antidiscrimination laws

In examining the concept of ambivalence in employment, disability benefits and the ADA, Mr. Muller, author of *Disability, Ambivalence and the Law,* writes:

> "The bulk of legal scholarship concerned with disability addresses federal regulation of employment. For the most part, this work focuses on the ADA's protections against employment discrimination. However, a growing set of scholars has begun to explore the interaction between antidiscrimination mandates and federal disability benefits. By most accounts, legal reforms in the past two decades have yielded a series of puzzling and frustrating failures. The sweeping antidiscrimination rhetoric embodied in the ADA did not prevent courts from construing the Act narrowly and prompted Congress to issue a rebuke in the ADA Amendments Act of 2008. Eligibility requirements for federal benefit programs tend to encourage individuals with disabilities to remain out of the workforce. For these reasons or perhaps others, the national employment rate for individuals with disabilities has remained stagnant in the two decades since the passage of the ADA.
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> Attention to ambivalence about disability helps to explain these outcomes and suggest appropriate reforms. Federal regulation of employment must walk a fine line between expecting too much and expecting too little of individuals with disabilities. Embrace of disability as valued or devalued threatens to yield employment outcomes that run afoul of one of these concerns; by ignoring one set of sentiments about disability, we distract our attention from the situations before us. This could appear in unduly high or low expectations for employees with disabilities….
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> Together, these two regimes make up a larger system characterized by structural ambivalence about disability. In one doctrinal area, disability is a valued difference protected against discrimination. In the other, it is a devalued difference addressed by government largesse. Of course, the two regimes are not quite as distinct as one might imagine. For example, people with disabilities capable of employment do not only garner government aid from antidiscrimination law; they may also benefit from vocational rehabilitation services, community programs, affirmative action, and the like. These services are consistent with a view of disability as a valued difference subject to social prejudice, but they could just as well reflect a view of disability as an inherently undesirable affliction that requires social supports. It is organizing principles, not necessarily specific policies that separate the two spheres and betray our ambivalence. (p. 513, 515)

Canadian decisions

Below is a summary of two contrasting decisions in two key areas of vocational rehabilitation which will illustrate how different an outcome can be depending on the facts and circumstances of the case.

The first two decisions involve disability insurance claims. They examine the responsibility of the insurer and insured to pursue rehabilitation once support is made available.

The second two decisions involve human rights complaints. They examine the scope of medical disclosure necessary to trigger a duty to accommodate an employee with a disability.

Although these are Canadian decisions, the issues are similar to those arising in the US, and the different outcomes may well reflect some of the ambivalence towards disability issues identified by Mr. Muller.

Who is responsible to pursue rehabilitation in a disability insurance setting?

The most significant recent Canadian decision examining issues regarding rehabilitation in a disability insurance claim is a recent Nova Scotia Court of Appeal decision ***Industrial Alliance Insurance and Financial Services Inc. v. Brine*** 2015 NSCA 104. In that case, the insurer had initiated a rehab program, but then terminated it after receiving an IME report. The court accepted that the policy did not impose on the insurer an obligation to provide a rehab program, but held that once the insurer had initiated a rehabilitation plan, it was expected to follow through in good faith.

The court wrote:

> "The Policy did not oblige the insurer to make rehabilitation services available to its insured. However, National Life decided to involve a rehabilitation counselor because of Mr. Brine's young age and the possibility that he may be able to return to work. In a December 1, 1995 letter to Mr. Brine, National Life advised that such services would be provide to assist him with his "efforts to return to the workforce, where practical." (para. 86)

In November 1995, Mr. Brine's treating psychiatrist wrote that his prognosis was good to excellent. In May 1996, he advised that when Mr. Brine's GAF (Global Assessment of Functioning) improved to at least 70-80 (at the time, he assessed it to be 55-60), it would be appropriate to consider rehabilitation efforts and a possible return to work.

Although Mr. Brine was not yet at the point where his psychiatrist felt that he would benefit from considering a possible return to work, National Life hired a rehabilitation specialist who met with Mr. Brine in January 1996 and then followed up with weekly phone calls. Mr. Brine testified at trial that he appreciated and was encouraged by her involvement. However, his status did not improve over a 30 month period, so National Life arranged for Mr. Brine to undergo a psychiatric IME in August 1998.

The IME psychiatrist wrote:

> "From a strictly psychiatric point of view, Mr. Brine's symptoms do not prevent him from working at this time. He is rageful but not severely depressed or suicidal and there is no history of psychosis or severe anxiety disorder. The absence of any work or re-training challenge may indeed worsen Mr. Brine's chronic rage symptoms as he finds himself ruminating about the workplace on a daily basis. Ongoing counselling with a maximizing of his medical treatment and decreasing of his alcohol intake may assist him in working through his anger in such a way that would sustain a return to the workplace." (para. 90)

Upon receiving this report, National Life terminated rehabilitation services for Mr. Brine.

The trial judge made a number of points critical of National Life's actions:

- it introduced rehabilitation when Mr. Brine's psychiatrist had said he wasn't yet ready for it;
- it relied on a 1997 report of Mr. Brine's psychiatrist to conclude that Mr. Brine was not improving sufficiently to participate in rehabilitation services, and did not consult with Mr. Brine's treating psychiatrist in the summer of 1998 at which time his condition apparently had improved; and
- it disregarded the potential value of rehabilitative support suggested by improvements noted in 1998 IME report.

In their defence, the National Life adjudicator had explained that:

- the list of treatment recommendations made by the IME psychiatrist was so onerous, she did not feel it was "fair" to expect Mr. Brine to attempt a return to work at the same time;
- she learned that CPP had approved Mr. Brine's application for disability benefits and figured that in such circumstances, claimants never return to work.

National Life appealed the trial judge's finding that its actions in relation to its rehabilitation initiative constituted bad faith. It argued that since it was under no obligation to approve rehabilitation in the first place, how could the discontinuance of rehab services constitute bad faith?

The Nova Scotia Court of Appeal emphasized that the duty of good faith was triggered when National Life chose to initiate rehabilitation. Although the policy explicitly stated that National Life had complete discretion over any rehabilitation initiatives, the court said this did not exclude an implied duty of good faith. Significantly, the court held that even if National Life did not breach an explicit term of the policy, it could still be in breach of an implied duty of good faith.

The Court of Appeal held that the questions which need to be asked are:

- did National Life deal with Mr. Brine's claim "fairly"?
- was its handling of Mr. Brine's rehabilitation "overwhelmingly inadequate"?
- did National Life introduce "improper considerations" in its decision-making?

The Court of Appeal accepted the trial judge's findings that the National Life adjudicator had ignored the medical opinion of Mr. Brine's treating psychiatrist when starting the rehab and she hadn't bothered to

find out what he thought when terminating rehab. Most importantly, National Life had applied an improper consideration when it decided that Mr. Brine would never return to work because he had qualified for CPP disability benefits. That was enough to justify punitive damages for breach of the duty of good faith.

What are the lessons to be learned from this case? I suggest the following:

1. if a rehabilitation program is commenced, it should not be unilaterally ended without credible justification;
2. it is wise to consult with the treating doctor (in this case the treating specialist) when starting *and ending* a rehabilitation initiative; and
3. it cannot be assumed that just because an insured has qualified for CPP disability benefits that rehabilitation services should be terminated.

In ***Conte v. The Canada Life Assurance Company*** [2005] I.L.R. I-4436, the issue was whether the employee, Ms. Conte, who had worked as a Customer Service Representative at a bank, was disabled from work and entitled to disability benefits. Ms. Conte had been injured in a motor vehicle collision and suffered from pain in her knees, back, hand, headaches, and problems with her mood.

The insurance policy contained the following provisions:

> LTD benefits are not paid if an employee (1) refuses to participate in a rehabilitation program or accommodated work, unless it is established that the employee's impairment prevents this; (2) the employee is not under the continuing care of an appropriate specialist who is a licensed physician or surgeon for professional treatment deemed appropriate for the condition being treated; (3) the employee is not participating in treatment that the insurer and the employee's physician consider appropriate; (4) the employee refuses any medical, psychiatric or psychological treatments that the insurer and the employee's physician recommend.

During the short-term disability period, the employer had Ms. Conte assessed by an orthopaedic surgeon who recommended that Ms. Conte start a graduated return to work while being allowed to stretch, move about, alternate positions and avoid lifting, climbing, squatting, kneeling and bending.

At trial, there was evidence that the bank had an extensive Accommodation Policy which included work station modifications, furniture or equipment design changes, modifications of working conditions including break times, hours of work or reassignment of duties required by the employee's functional limitations. (para. 59) Ms. Conte testified that she was never offered these kinds of accommodations. However, the judge relied on evidence of the bank's Accommodation Policy and the bank's legal obligation to accommodate to conclude that this would have been available and wrote:

> "The Bank discharged its legal duty to accommodate Ms. Conte. Her refusal to participate in accommodated work in March 2000 was not justified. She failed to explore other accommodations that may have been more acceptable to her. She took no steps, let alone any

> reasonable steps, to facilitate the search for accommodation or the implementation of the accommodations."

On the issue of the insured's duty to pursue rehabilitation, the court concluded:

> "When an employee fails to co-operate in rehabilitation through recommended treatment and is not under the continuing care of an appropriate specialist for a treatable condition and refuses to try accommodated work in circumstances such as these, a long-term disability insurer cannot be expected to continue to pay benefits. This leaves the insurer without any ability to authenticate the claim. It leaves the Court in no different position. Chronic pain cases are difficult cases to adjudicate, particularly where there is little or no objective medical evidence of a disabling condition. If Ms. Conte had made a concerted effort to rehabilitate herself and if she had made reasonable attempts to return to work, but had failed, this trial could have turned out differently. When this evidence is lacking, claims of this kind are unlikely to succeed." (para. 89)

In the end, the court denied Ms. Conte's disability claim, concluding that she was able to obtain a great deal of assistance from her family and her employer and that returning to work "will help rather than harm her ultimate recovery and will lead her back to the fun and energetic person she was before her accident."

What triggers an employer's obligation to address an accommodation request?

Another challenging aspect of vocational rehabilitation is determining the amount of information that an employer can properly require before it is required to investigate whether it can accommodate an employee with a disability.

In ***Boehringer Ingelheim (Canada) Ltd. v. Kerr*** 2010 BCSC 427, the employee, Ms. Kerr, was diagnosed with bilateral posterior subcapsular cataracts, which made it difficult for her to read and write. Ms. Kerr applied for and was paid long-term disability benefits for approximately two years when her disability insurer terminated her benefits. She appealed the disability decision and at the same time, advised her employer (BICL) that she was interested in trying to return to work. BICL responded by requesting objective medical information. Ms. Kerr provided BICL with a report from her doctor who thought she might be able to work. Seven months later, BICL sent Ms. Kerr a Disability Accommodation Questionnaire. Ms. Kerr filed a Human Rights complaint but also arranged for experts to provide additional information requested in the Questionnaire. Without seeking any input from Ms. Kerr, BICL issued a standard return to work plan which, according to the court, was "a woefully inadequate document".

The issue before the court was whether BICL was guilty of discrimination when it required Ms. Kerr to provide objective evidence establishing that she was capable of returning to work. BICL argued that it needed to understand how Ms. Kerr could perform work which, for more than four years (by then), she and her doctors had repeatedly said she was unable to perform as a result of her disability, even with accommodation. BICL argued that until it received an expert report, it was not possible to determine

whether Ms. Kerr was capable of performing the work and it was not possible to develop a return to work plan.

The court referred to the 3-part test for determining whether there is *prima facie* discrimination. The complainant must prove that:

1. he or she had (or was perceived to have) a disability;
2. he or she received adverse treatment; and
3. his or her disability was a factor in the adverse treatment.

The court upheld the Tribunal's finding that BICL's failure to take steps to return Ms. Kerr to work after she communicated her desire to return constituted adverse treatment. The court reasoned that an employee shouldn't have to prove they can work because the employee may not be aware of what could be done by way of accommodation which would enable them to do their job. It also noted, however, that with the assistance of the CNIB, Ms. Kerr had made it clear to BICL that her compromised ability to read and write could be accommodated through adaptive equipment.

The court upheld the Tribunal's award for damages on the basis that BICL had discriminated against Ms. Kerr.

In ***Complex Services Inc. (c.o.b. Casino Niagara) v. Ontario Public Service Employees Union, Local 278***, 2012 CanLII 8645, a dispute arose as to the employer's right to confidential information regarding its employee's mental illness. The employer (CS) did not have an accommodation policy or guidelines in place. It was aware that the employee (known only by her initials) had a physical disability and in addition, that she had attended a drug and alcohol treatment centre and was suffering from a mental illness. Shortly after the employee returned from sick leave, CS advised the employee of its intention to investigate alleged misconduct pre-dating her leave and wrote "*If there is any medical reason why you are unable to participate, please advise immediately and provide us with a medical note detailing the particulars*." The employee sought to have the union act as intermediary in all communications with CS. For its part, CS sought to have the employee's medical records reviewed. When the employee resisted this proposal, CS ended up advising the employee to "remain away from the workplace and provide medical documentation that clearly states [your] limitations." (para. 56)

The employee alleged that CS was harassing her, in contravention of the Ontario *Human Rights Code*. CS alleged that the employee was thwarting its right to information that would enable it to consider what accommodations were necessary and/or appropriate.

The Tribunal noted the challenges of addressing accommodation issues in cases where an employee suffers from mental illness and observed:

> "I don't know how an employment accommodation can even begin much less properly proceed unless the employer has some information of the nature of the disability. That is particularly true in cases of mental illness. There are many kinds of mental illness. Further, a particular mental illness may manifest differently in different individuals, and may require differential

> treatments, which may include medication which may have significant side effects. Some mental illness, particularly those with psychotic features or symptoms, may raise legitimate workplace health and safety concerns for the disabled individual, other employees, or customers or clients." (para. 82)

Under the Ontario Human Rights Commission's Policy, "the employee has an obligation to ask for accommodation and to provide sufficient information, including necessary otherwise private confidential medical information, to establish the accommodation required, and to participate in and facilitate both the search for and implementation of accommodation – whether or not the accommodation available is "perfect" from the employee's subjective perspective."

The legal principles around the scope of medical disclosure required by an employee were outlined in the following excerpt:

> "An employee's personal medical information is generally acknowledged to be private and confidential. However, it is well established that an employer is entitled to access sufficient information for legitimate purposes.. to ensure that the employee can work without jeopardizing her safety, or [those of others in the workplace]. An employer is entitled to only the least such information necessary for the purpose and an employee should generally not be required to disclose their medical files, or even the diagnosis or treatment. However, exactly what is required will depend on the circumstances and purpose – and may very well include diagnosis, or treatment, or other information."

In another passage, the Tribunal summarized the extent of medical information that would generally be required for accommodation purposes as follows:

1. the nature of the illness and how it manifests as a disability;
2. whether the disability is permanent or temporary and the prognosis;
3. the restrictions or limitations that flow from the disability;
4. the basis for the medical conclusions, including examinations or tests performed; and
5. the treatment, including medication which may impact on the employee's functioning.

The Tribunal concluded that CS was well within its rights to require disclosure by the employee of her medical records.

From a vocational rehabilitation perspective, it is clear that both employees and employers risk experiencing adverse outcomes if legitimate and informed steps are not taken to facilitate a return to work. While every situation must be treated as unique, some basic principles inevitably guide the discussion. Not surprisingly, all parties need to have a reasonable understanding of:

a) the employee's disability, which involves securing current and relevant medical evidence and opinions regarding the insured's capacity to work; and

b) the job requirements, including the full scope of accommodation which an employer is able to provide to the point of undue hardship.

Conclusion

It is difficult to rationalize the cases in this area of the law. This is in part because one is dealing with different legal frameworks and consequently different legal obligations (disability contracts v. human rights legislation). However, other factors, such as ignorance and/or bias regarding the nature of various illnesses and disabilities (pain, mental health) may also play a part.

In the final analysis, Mr. Muller advocates for our laws to recognize society's ambivalence towards disability for what it is and to work with the competing and/or conflicting values found in disability law and antidiscrimination laws. He concludes:

> "In many of the contexts examined here, the law would do best to strive for mud rather than crystals. This may be an uncomfortable and troubling prescription….. My more modest hope is that disability advocates and policymakers will recognize their conflicting emotions about disability and relax their efforts to find coherent meaning within it." (p. 521)