CHAPTER V: MRP ISSUES

A. THE DETERMINATION OF MEDICAL CAUSATION

Summary of Issues

There are several sub-issues associated with this topic:

1. Early determination of medical causation:
   a. Should medical causation be definitively established at an early stage in the claims adjudication process?
   b. If so, by whom?
   c. Is independence required in this determination?
   d. Should the determination be binding?

2. Integration and independence on appeal:
   a. Is independence required in the determination of medical causation on appeal?
   b. If so:
      (i) Should such a process be integrated with an independent appeal process?
      (ii) Should an independent determination of medical causation on appeal be binding?
      (iii) Who should have authority to initiate this determination?

Each of these sub-issues is examined below.

Law and Policy

a. Who makes the initial determination of medical causation?
Initially, findings of medical fact are derived from several sources by the WCB claims adjudicator. In most cases, these findings are based on information in the worker's application and the employer's reports and medical reports.\(^1\) For example, WCB claims adjudicators rely on medical facts found in the "Form 8" ("Physician's First report.") and the "Form 11" ("Physicians Progress Reports") or comparable forms\(^2\) which are filed regularly by attending physicians and other qualified medical practitioners attending or consulting on a case.\(^3\) Normally it is the workers' physician who fills out these forms.

In a minority of cases more formal investigative procedures may be used.\(^4\) The WCB has authority to request an "at Board exam," conducted by a medical expert who is a WCB employee. There is no requirement that this be done in every case.

b. Who reviews the initial determination of medical causation?
The only opportunity for an independent medical assessment is through the MRP process. The MRP process exists as an entirely separate level of review, which may be
initiated at various stages of the process (i.e., immediately after initial claims adjudication, subsequent to a WCRB appeal or after an appeal to the Appeal Division). However, it is often referred to as the third and final level of appeal, since its decisions are conclusive and not open to review under s.65 of the Act.

c. How independent is the MRP process?

The physicians who comprise an MRP are independent of the WCB. An MRP panel has been described as "an independent group of non-biased, non-political physicians trying to objectively examine the facts." However, the MRP department, which administers the MRP process, is not independent of the WCB. The MRP Registrar is an officer of the WCB and reports directly to the Panel of Administrators of the WCB through the Chair.

Section 58 of the Act empowers the Lieutenant Governor in Council (LGC) to appoint Chairs (and Acting Chairs) of MRP's. The LGC is also empowered to appoint a medical committee which prepares a list of Specialists in particular classes of injuries and disabilities. A joint medical committee of the College of Physicians and Surgeons of B.C. and of the B.C. Medical Association appoints the Specialists. The appropriate specialty for each appeal is designated by the Registrar. MRP's are composed of three physicians, none of whom are WCB employees. The Chair of an MRP is a general practitioner, appointed from a rotating list, while the other two physicians are Specialists. Under s.59(1) of the Act, no Specialist can sit on an MRP who has treated the worker, acted as a consultant in the worker's treatment, or is a partner or practices together with a Specialist who has treated the worker. Partners who practice medicine together are also restricted from sitting on the same panel.

Under s.59(1) of the Act, the WCB must, within a reasonable amount of time, sent a notice by registered mail to the worker and the employer requiring each to nominate a Specialist from a list provided by the WCB under s.58(2) of the Act, within 8 days of receipt of the notice. The worker and employer are asked to pick their top 4 choices in descending order (and are told that they need only ultimately pick one choice). This is done for scheduling purposes.

If the party who commenced the appeal fails to nominate a Specialist, no further proceedings will be taken. If the other party fails to do so, the Minister will appoint a Specialist.

d. Who can initiate an MRP review?

An MRP exam may be initiated by the worker or the employer where either one is aggrieved by a medical decision of "the board" (a WCB adjudicator or the Appeal Division), or by a medical decision of the WCRB, and there is a bona fide medical dispute to be resolved. The applicant has 90 days from the finding or decision to appeal the decision. This involves writing to the WCB and sending a sufficiently detailed certificate from a physician certifying that there is a bona fide medical dispute to be resolved. A Medical Appeals Officer or the Assistant Registrar will decide whether a valid physician's certificate has been provided in support of the appeal.
As well, the WCB or the Appeal Division may refer a matter to an MRP panel. Under s.58(5) of the Act, "the board may decide the worker shall be examined by a medical review panel, in which case he shall be so examined in the manner prescribed by this section". For this purpose, the board includes the Appeal Division. Under Decision of the Governors #1 the Appeal Division may seek medical opinions independent of those offered by the parties or the WCB.

Under s.6(3) of the Workers Compensation Act (Review Board) Regulation, BC Reg. 32/86 "[t]he Review Board may require and receive medical or other evidence and information on oath, affidavit or otherwise as it in its discretion it considers proper to make a fair decision." Under s.6(4) of the Regulation "[t]he Review Board may require a worker to attend for an examination by a physician chosen by the Review Board."

A. Early Determination of Medical Causation

a. Should medical causation be definitively established at an early stage in the claims adjudication process?
b. If so, by whom?
c. Is independence required in this determination?
d. Should the determination be binding?

Submissions and Reports

MRP Advisory Committee Member
Ian Connolly, MRP Advisory Committee member and Chair, recently commented that, before any appeal is allowed to proceed, the worker should be required to be examined by a WCB doctor. In his view, many cases would not reach the MRP level if this occurred more frequently.

Acting Chief Appeal Commissioner
Acting Chief Appeal Commissioner, Cassandra Kobayashi, also recently acknowledged that there would be an advantage to establishing medical certainty at an earlier stage. She agreed that one benefit of adopting such a proposal would be that medical disputes would be brought to an earlier conclusion.

Stakeholder Counsel: Sayre
Stakeholders agreed with the goal of establishing medical certainty at an early stage, but argued that a WCB medical assessment is insufficient. For example Sayre, on behalf of injured workers, submitted that, while the worker's physician should have a primary role during initial adjudication, an independent medical assessment should also be available at that stage:

Throughout a claim, an injured worker's condition should be assessed and treatment should be determined by the worker's treating physicians. If the Board or worker wishes to dispute the assessment of the treating physicians, any additional evidence that may be needed should be obtained by a referral to an
independent Specialist, not a medical adviser employed by the Board. At no point should the Board or appeal tribunals assume that the worker’s attending physicians are biased.\textsuperscript{18}

**Current and Former MRP Registrars**

When asked whether the MRP process is appropriately situated in the hierarchy of appeals, former MRP Registrar Martin replied that there are two problems with the current positioning of the MRP process as the final appeal:

1. **The number of times the claim has gone through the appellate process (the “treadmill”) is relevant.** One may end up with an MRP panel viewing facts already five to seven years old. Because they are looking back through time, the impact on the worker may be counterproductive. The dispute is no longer current, there is no way anymore to help the claimant out. The medical determination should take place much earlier and be more available to the claimant, more timely. It should be moved up so that it will be a more useful, accessible tool. This would offer more of a chance of mitigating the circumstances of disabled workers.

2. **The process was dreamed up in the 1950s. It made sense at that time. But now, given the disability picture, many factors are non-medical.** The MRP process as it is currently structured ignores the non-medical issues. It has a narrow focus and doesn’t give needed answers. It isn’t really the end of the road. For example a person could “win” 6 to 8 weeks of disability benefits six years later. This doesn’t help the person much at that late stage. It would be better if the medical determination were to be moved to an earlier stage and broadened, for example to include dentistry, chiropractic, naturopathic fields. There have been requests for such a broadening. The Act is strict that it must be medical.\textsuperscript{19}

Similarly, MRP Registrar Sheardown commented that there should be an opportunity for the parties to obtain an independent, medical opinion before the matter leaves the initial adjudication stage, in cases where the practitioner and the WCB doctor disagree. Although she felt such an opinion should carry weight, she did not believe that it should be final and binding.\textsuperscript{20}

**Stakeholder Counsel Steeves**

Steeves, on behalf of the BC Federation of Labour, acknowledged that there may be some merit to having medical causation determined at the beginning of the process, but expressed some concern that it would be more difficult ensure “the clarity of the non-medical issues” since doctors may not have they expertise to separate factual and legal issues from medical ones. He suggested that a doctor might base his or her opinion on a set of facts that are later (e.g. on appeal) found to be untrue. For this reason, he concluded that an early determination of medical causation by a doctor should not be final and binding. He pointed out that, under the current system, most cases are relatively focused by the time get to a Medical Review Panel, so this lack of expertise is not as much of a concern.\textsuperscript{21}
Steeves also made the following submission about the initial determination of medical causation:

[We] have concerns about the reduced role of medical advisors with the new changes at the Board. One concern relates to [the use of] nurse advisors … Another concern relates to the role of medical advisors in the adjudication of ASTD claims…We have some concerns about the competency of Board medical staff when it comes to giving medical opinions about ASTD claims. However, we also recognize the value of competent medical advice to adjudicators and other Board officials. For example, we believe that medical causation is, by definition, a medical question. Computer programs may provide some data that can be used by medical professionals but they cannot make the informed medical judgements that a doctor can make. We recommend that Board policy and procedures be amended to confirm that determination of medical causation is the responsibility of a qualified and competent medical practitioner.\textsuperscript{22}

We recommend that the Panel of Administrators assert some control over the introduction of Nurse Advisors into the adjudication of claims. Specifically, the policy and practice issues must be carefully delineated, the role of nurse advisors and medical advisors must be clearly defined and there must be an effective means of measuring the introduction and ongoing role of nurse advisors in the adjudication of claims.\textsuperscript{23}

**Other Jurisdictions**

[In Progress]

**Discussion**

It is clear from submissions that some claimants feel that their medical assessment by a WCB adjudicator was insufficiently independent. Yet these same claimants may hesitate to initiate an MRP review until after all of their appeal avenues have been exhausted. This appears to be a systemic problem. MRP reviews are seen as the final stage of the appeal process because MRP certificates are conclusive and not open to review under s.65 of the Act.\textsuperscript{24} Appellants are aware that an early MRP determination will preclude an appeal to the WCRB or Appeal Division on the same issue. As a result, they are reluctant to initiate an MRP review until they have had all of their "kicks at the can." They are unwilling to forgo their appeal rights despite the fact that an early determination might provide a better opportunity for them to mitigate their circumstances.

Medical causation issues may therefore not be definitively established by the MRP process until years later, after the WCRB and the Appeal Division appeals have been concluded. This means that appeals are decided on the basis of medical "facts" which have not been tested through an independent medical assessment. The end result is in sharp contrast to a tort system, where medical causation issues are established at the outset, along with non-medical issues.
This approach may be more understandable when viewed in its historical context. Former MRP Registrar David Martin recently observed that, in the past, it made more sense to determine medical causation in the final stages of the adjudication process because the "trauma model" was the standard at that time. In his view, the determination of medical causation has become more difficult in today's context because the trauma model is no longer necessarily applicable -- for example, in claims involving stress or soft tissue injuries.25

By today's standards, the current approach is arguably illogical, outdated and counter-productive. Claimants clearly want, and would benefit from, an early, independent determination of medical causation. There appear to be no compelling reasons why they should be systemically discouraged from seeking one.

Steeves' concern (that it may be more difficult ensure the clarity of non-medical issues because doctors may not have the expertise to separate factual and legal issues from medical ones) would be manageable if independent early determinations of medical issues were to be made non-binding. This would provide an opportunity for such errors to be corrected on appeal.

If early, independent medical determinations were to be instituted, a fair process for selecting, training, monitoring and disqualifying independent doctors would have to be established. Discussions found later in this chapter examine various factors to be considered in the appointment of MRP Chairs and Specialists. While those discussions focus primarily on the appeal stage, the analysis may be equally applicable to an early, independent, medical determination. That is, it may be possible to use the same or similar list of doctors, selection process, qualification criteria, terms of appointment, renewal & disqualification processes, education, training and performance assessments.

**Options/ Recommendations**

It could be recommended that:

- an independent medical assessment should be made available to workers and employers during initial claims adjudication; and

- an early independent medical assessment should not be final and binding.

If the Royal Commission recommends an early independent medical assessment, it should also be recommended that a fair process for selecting, training, monitoring and disqualifying independent doctors be established. Discussions and recommendations found later in this chapter respecting MRP appeals should be considered in this light. That is, it may be possible to use the same or similar list of doctors, selection process, qualification criteria, terms of appointment, renewal & disqualification processes, education, training and performance assessments as are used on appeal.
2. Integration and independence on appeal

a. Is independence required in the determination of medical causation on appeal?
b. If so:
   (i) Should such a process be integrated with an independent appeal process?
   (ii) Should an independent determination of medical causation on appeal be binding?
   (iii) Who should have authority to initiate this determination?

Submissions and Reports

a. Perceived lack of independence of the MRP department

Stakeholder Counsel - Sayre
Sayre made the following comments about a perceived lack of independence associated with the MRP department:

*Injured workers are also concerned with having an independent tribunal that will adjudicate disputes when they are in conflict with the Board over how their claim should be handled or in this case how the medical issues in their claim should be determined…* [the MRP Registrar is] an employee of the WCB… work[s] in the [WCB] building and all of the functions that [the MRP Registrar] and the staff … are performed as employees of the WCB.*26*

He elaborated in his written submission as follows:

*At the front end (by which we mean all of the steps preliminary to the MRP meeting, examining the worker, and issuing its certificate which answers the questions asked of it pursuant to s. 61), the process is entirely controlled by the Board. This is itself a difficulty, given the lengthy conflict likely to have taken place between the worker and the Board by the time a dispute reaches the MRP. How likely is it that a worker, after battling the adjudicator, Review Board, and Appeal Division (in most cases), will trust a tribunal which depends entirely on WCB to file and process the appeal, appoint the panel members, set up the hearing, define the issues, create the evidentiary record, etc.?*27*

b. Integration of MRPs into an independent appeal process

Employer Submissions

A number of submissions recommend integration of the MRP Department into one of the existing appeal processes or into a final, independent appeal process, in order to ensure its independence.*28* For example, one employer stated that "the functions of the Appeal Division, the Medical Review Panel and the Review Board should be combined into one external appeal tribunal."*29*
BC Ombudsman
This suggestion was also made by the Ombudsman in 1987, who stated that "applications for referral of medical disputes to the MRP [should] be decided by the WCRB." 30

WCRB
It was submitted by the WCRB that the MRP process should be integrated with a single, independent appeal tribunal and that medical decisions arising from this process should be final and binding:

We propose the creation of Health Care Advisory Panels (HCAP’s) drawn from a list of health care professionals to replace the existing MRP process. This list will be comprised of Specialists in each recognized specialty and general practitioners and such other health care professionals as may be appropriate, all of whom must be licensed in British Columbia. A committee will be struck by the Appeal Tribunal consisting of equal representation from labour, management and the Tribunal to create the list. The intent is to eliminate all of the procedural and jurisdictional difficulties that have arisen with respect to MRP’s while still retaining the benefits of the independence, expertise and authority of health care professionals.

a. The HCAP’s will operate under the administrative authority of the Appeal Tribunal.

b. An Appeal Tribunal panel may refer a medical question to an HCAP. The panel may do so either on its own motion or on application by either of the parties, however, it is the panel’s decision to make.

c. The members of an HCAP will be appointed by the Tribunal from the list.

d. The HCAP certificate will be binding on the medical issue and it will be incorporated into the panel’s decision.

Stakeholder Counsel - Winter
Winter, on behalf of employers, suggested that variation of the WCRB proposal be adopted. He did not agree that the medical determination should be binding on appeal:

The employer community says the Medical Review Panel should be replaced with a system whereby the appeal tribunal has the discretion to refer a medical issue to an independent specialist or panel – it doesn’t have to be a panel necessarily - for an opinion and the referral could include a requirement that the worker attempt to be examined – that would be up to the tribunal and the parties can ask the tribunal for that referral. But it would be a decision of the tribunal whether to do it or not. It is similar to the proposal made by the Review Board in their written submission on Health Care Advisory Panels – the main difference being that the certificate should not be binding…. It would end up being part of the overall medical evidence and the overall evidence before the tribunal which
would determine how much weight they should place on it. ...I can’t imagine why it wouldn’t be given high weight –but again it should be a matter of weight - not binding.  

**Stakeholder Counsel - Sayre**

Similarly, Sayre submitted, on behalf of injured workers, that the MRP process should be integrated with an independent appeal tribunal:

> Medical Review Panels serve a vital, though limited function, in adjudicating medical disputes. However, the process suffers from delays, and also from weaknesses at both the front and rear ends of the system, where the Board continues to control both the establishment of the panels and the implementation of their decisions. While we certainly can’t support the Review Board’s suggestion that the M.R.P. become nothing but an advisor to the general appeal tribunal, we do see much benefit in partially integrating the M.R.P. process by having a common appeal registry (something the Ombudsman recommended in his 1987 report) and by having an expedited procedure for the worker to challenge the Board’s determination of the non-medical consequences of a certificate.  

Some of the recommendations in the Review Board’s submission are worthy of consideration. For example, incorporating the MRP procedure as a means of resolving a medical issue in an appeal may make sense. Adverse decisions rarely involve just a medical issue - the actual dispute is always over denial or termination of benefits, or the amount of benefits, based on a medical determination. There could be a real advantage to injured workers in having an general appeal tribunal such as the Review Board able to decide what benefits flow from the medical decision.  

He elaborated on the Ombudsman’s proposal as follows:

>The Ombudsman wrote that under the proposed system an appellant would appeal to the Workers’ Compensation Review Board. If the Review Board were to find an important medical issue in dispute it could, at the request of the worker or the employer or on its own initiative, refer the matter to a Medical Review Panel. [T]here would still be the right of a party to invoke the Medical Review Panel process but it would be done by filing a single appeal to the review board. That has considerable merit in our view because of the fact that very few issues can truly be described as purely medical issues.  

Sayre took the position that this medical determination should be binding.  

**Former MRP Registrar**

Former MRP Registrar David Martin recently commented it is a problem that all appeals (WCRB, Appeal Division, MRP) are separate administratively. He suggested that one could combine administration of some of them, including the MRP process, without compromising the appeal process.
Other Jurisdictions

[In progress Perrin and Thorau to verify -- Most jurisdictions do not appear to have an MRP process as a separate level of review. Weldon Brake stated that in NFLD the MRP process was integrated with the appeal division and that the appeal body sets up MRP type panels. Saskatchewan also appears to have an independent MRP process. The Chair is appointed by the Board in consultation with the Sask Medical Association. Two additional members are selected by the person requesting the review from a list of names provided by the Board.]

Discussion

Integrating the MRP process with an independent appeal authority makes sense for several reasons.

Historically, administration of the MRP process fell under the Appeal Division. The Governors took over this role in 1991. The decision to remove the MRPs' administration from the Appeal Division and to make it a "separate entity as a department" was made in order to "further the independence of the MRP process, and to eliminate any arguments regarding conflicts of interest within the Appeal Division."

However, it is clear from submissions that the MRP process is still broadly perceived as insufficiently independent, despite its removal from the Appeal Division. This is because the MRP department, which administers the MRP, is part of the WCB. The fact that the MRP Department is located within the WCB complex in Richmond compounds the problem. The perception arises that objectivity could become clouded or a conflict of interest could arise by virtue of day to day familiarity.

Administrative and geographic separation of the MRP from the WCB would eliminate the perceived lack of independence. Integration of the MRP into an independent, final appeal authority would also eliminate one level of appeal, expedite the process, combine administrative resources, reduce costs and eliminate other administrative inefficiencies (e.g. different computer systems, duplication of paperwork).

If a new, independent MRP type process is recommended by the Royal Commission, it follows that an additional recommendation should be made concerning the binding nature of the medical determination. Two options have been suggested in this regard:

- the decision of the new MRP process could be final and binding on the medical issue and incorporated into a final, independent appeal body's decision; or

- the decision of the new MRP process could be non-binding -- its decision would have weight and be considered as part of the overall evidence put before the independent, final appeal body.
The first option is preferred by those who believe that:

- doctors are in the best position to make medical decisions; and
- the issues have become sufficiently focussed on appeal, so that it is not of great concern that doctors may have difficulty separating factual and legal issues from medical ones.

The second option is preferred by those who believe that:

- doctors lack the expertise to separate factual and legal issues from medical ones, even on appeal; and
- appeal authorities with appropriate knowledge and skills are in the best position to consider medical, legal and factual issues and render a final, binding decision.

Both approaches appear workable. [The jurisdictional comparison may assist in making this decision].

Several submissions have been received suggesting that the independent appeal body could be given authority to refer a medical question to the new MRP process, either on its own motion or on application by either of the parties. This is similar to the current approach in that a worker, employer or "the Board" (in practice usually the Appeal Division) may initiate an MRP review. However, a major difference is that, currently, the MRP Department makes the determination about whether there is a bona fide medical dispute. According to submissions, this decision should be made by an independent authority.

**Recommendations/ Options**

It could be recommended that:

- A new MRP process should be administratively and geographically separated from the WCB and operate under the administrative authority of a new final independent appeal body.
  [Note: full discussion and recommendations concerning a new, independent appeal authority are found in a separate chapter of this report].

- The independent appeal authority be given the authority to refer a medical question to the new MRP process, either on its own motion or on application by either of the parties.

It could be recommended that the medical certificate of the new MRP process should be either:

- final and binding on the medical issues and incorporated into a final, independent appeal body's decision; or
non-binding -- its decisions would have weight and be considered as part of the overall evidence put before the independent, final appeal body.
B. **APPOINTMENT PROCESS FOR MRP CHAIRS AND SPECIALISTS**

**Summary of Issue**

Ensuring independent and competent MRP members in the appointment process has been a topic of debate since the Jenkins Report. These issues will continue to be relevant whether or not the Royal Commission recommends the establishment of a new independent MRP process. Sub-issues include the following:

- Should the Lieutenant Governor in Council continue to carry out the appointment of Chairs and Specialists?
- What role should be given to the Joint Medical Committee of the College of Physicians and Surgeons of B.C. and the BCMA in the appointment of Specialists (s. 58(2))?
- Should qualified medical experts be consulted?
- Should the interests of worker and employers be balanced through input from these groups during the appointment process?
- Should the appointments be for a specified term? If so, what length?
- What qualification criteria should be used?
- What renewal and termination processes should be used?

**Law & Policy**

Section 58 of the Act empowers the Lieutenant Governor in Council (LGC) to appoint Chairs (and Acting Chairs) of MRP’s. The LGC is also empowered to appoint a medical committee which prepares a list of Specialists in particular classes of injuries and disabilities. A joint medical committee of the College of Physicians and Surgeons of BC (“CPSBC”) and of the B.C. Medical Association (“BCMA”) appoints the Specialists. The appropriate specialty for each appeal is designated by the Registrar. MRPs are composed of three physicians, none of whom are WCB employees. The Chair of an MRP is a general practitioner appointed from a rotating list, while the other two physicians are Specialists -- one nominated by the worker and the other nominated by the employer, chosen from a list supplied by the WCB.

Other than the preclusions listed under s.59(1), duration of appointments, conditions of renewal and termination and selection criteria are currently unspecified in the Act and published policy. Under s.59(1) of the Act, no Specialist can sit on an MRP who has treated the worker, acted as a consultant in the worker’s treatment, or is a partner or practices together with a Specialist who has treated the worker. Partners who practice medicine together are also restricted from sitting on the same panel.

1. **Should the Lieutenant Governor in Council continue to appoint Chairs? Should qualified medical experts or other members of the community be consulted as part of this process?**
Submissions and Reports

Jenkins Report
Jenkins made the following recommendations regarding the appointment of MRP Chairs:

The appointment of Chairmen should continue to be made by the Lieutenant-Governor-in-Council (Order-in-Council appointment). It is important to maintain the independent, non-political nature of the appointment. There is a quasi-judicial aspect to the appointment. This arrangement carries the connotation of a special status, which is appropriate. The Lieutenant-Governor-in-Council should consult with the Board of Governors prior to making appointments. The Board of Governors should consult with the Joint Medical Committee prior to giving their advice.44

The community should be kept informed about the process of appointing Chairmen and be assured as to the fairness of this process with regard to securing the best possible physicians without bias. Consideration of region/gender should be part of this process.45

MRP Advisory Committee
In 1992 the MRP Advisory Committee recommended that there be a role for the Joint Medical Committee, the MRP Advisory Committee, the MRP Chairs and possibly the Board of Governors (Panel of Administrators) in the appointment of MRP Chairs:

There should be a "process" established for appointing Chairmen. Applications should be forwarded to the Registrar. A short list would be established by the Advisory Committee and the joint medical committee meeting jointly with the Registrar. The MRP Chairmen as a group would then be asked whether they had any objections or other comments with respect to any of the individuals on the short list. It is not clear what role the Board of Governors should have with respect to the recommendation forwarded to the Minister.46

WCRB Submission
It was recently submitted by the WCRB that the following new appointment process be adopted:

We propose the creation of Health Care Advisory Panels (HCAP's) drawn from a list of health care professionals to replace the existing MRP process. This list will be comprised of Specialists in each recognized specialty and general practitioners and such other health care professionals as may be appropriate, all of whom must be licensed in British Columbia. A committee will be struck by the Appeal Tribunal consisting of equal representation from labour, management and the Tribunal to create the list. The intent is to eliminate all of the procedural and jurisdictional difficulties that have arisen with respect to MRP's while still retaining the benefits of the independence, expertise and authority of health care professionals.47
**Discussion**

Jenkins recommended that the Lieutenant Governor in Council should continue to appointment MRP Chairs. The reasoning underlying this position is that such appointments should be "independent," "non-political" "quasi-judicial" and should have "special status."

Although the WCRB recommended that different authority make the appointment (i.e., a new, independent appeal tribunal in consultation with representatives from labour and management), the underlying reasoning is similar, in that the appeal authority would also enjoy a special status and a high degree of independence.

**Options/Recommendations**

It could be recommended that the Lieutenant Governor in Council continue to appointment MRP Chairs; or

If the Royal Commission recommends integration of a new MRP type process with an independent appeal authority, it could be recommended that this appeal authority should appoint MRP Chairs.

As well, it could be recommended that some or all of the following authorities be consulted in the appointment process:

- the Board of Governor/ Panel of Administrators;
- the Joint Medical Committee;
- the MRP Advisory Committee,
- MRP Chairs; and
- a committee consisting of equal representation from labour and management.

It could also be recommended that information about the process of appointing Chairs be made more accessible to the public.

[The jurisdictional comparison may assist the Commissioners in making this decision]

2. **Should the Joint Medical Committee of the continue to appoint Specialists?**

**Should other qualified medical experts be consulted in the appointment of Specialists?**

**Submissions and Reports**

**Jenkins Report**

Jenkins made the following recommendations in this area:
The current practice of the appointment of Specialists to the MRP list by the Joint Medical Committee of the College of Physicians and Surgeons of B.C. and the BCMA (s. 58(2)) is appropriate to continue. The committee should be expanded to include the Dean of the Faculty of Medicine, University of British Columbia or designate. The committee should be receptive to recommendations from the Chairmen, coordinated by the Registrar, MRP.

The current practice of the "medical committee members" being selected by the nature of their position is satisfactory. This committee is thus composed of the Registrar, College of Physicians and Surgeons of B.C., the Executive Director of the BCMA, and the Assistant Executive Director of the BCMA (who acts as Chairman). The committee should be expanded to include the Dean of the Faculty of Medicine (or designate) and to include a member at large, both from the College and the BCMA.

...The guidelines and criteria used by the Joint Medical Committee for the selection of Specialists for the MRP list should be more formalized and made public to the medical community and community at large.

WCRB
As noted above, the WCRB proposed that "HCAP’s" replace the existing MRP process. A list of BC Specialists, general practitioners and other health care professionals would be created by representatives from labour, management and the proposed new appeal tribunal. The WCRB proposal does not distinguish between Chairs and Specialists, and is equally applicable to both.

Discussion
The above proposals address three different but equally valid concerns:

- The Jenkins recommendation recognizes the need for a high degree of medical expertise in the appointment of Specialists (i.e., involving the CPSBC; BCMA; Dean of UBC Faculty of Medicine; MRP Chairs).
- By contrast, the WCRB recommendation focuses on the need for political balance in the appointment process (i.e., involving representatives from labor and management).
- Finally, Jenkins has highlighted the need for transparency and public accountability (increasing public accessibility to the process).

Recommendations/ Options
It could be recommended that some or all of the following groups be brought together to form a Specialists appointment committee, or consulted during the Specialists appointment process:

- CPSBC;
- BCMA;
- Dean of UBC Faculty of Medicine;
- MRP Chairs; and
- representatives from labour and management.

It could be recommended that criteria used in the selection of Specialists be more formalized and made accessible to the public.

3. **What qualification criteria should be used the appointment of Chairs and Specialists?**

**Submissions and Reports**

**Jenkins Report**

Jenkins made the following recommendations concerning the qualifications of Specialists:

> A formal, stated list of qualifications should be made available for a Chairman’s position by the Joint Medical Committee. In addition, a job description, guidelines of duties and functions should be clearly stated by the Joint Medical Committee and made available to the Registrar and Chairmen for their input and approval. The Registrar, MRP would coordinate and recommend the statement to the Board of Governors for final approval.51

> Non-physician health-care givers should not be appointed to Panels. Their medical base of knowledge would be too limited for the medical issues that present to MRP. However, appropriate consultation should be encouraged.52

> Panel Chairmen should be required to have some knowledge of occupational medicine or industrial worksites, but not necessarily have the specialty certification in this specialty.53

He also recommended that criteria for renewal of Chair's appointments be developed:

> Criteria for re-appointment should be developed by the Registrar and approved by the Board of Governors, joint Medical Committee and Chairmen, MRP, prior to final approval by the Lieutenant-Governor-in-Council.54

**MRP Advisory Committee**

In 1992 the MRP Advisory Committee also made the following recommendations regarding qualification criteria for MRP Specialists

> The position should not be restricted to BCMA members or persons in active practice. Nor should there be any age restriction.55
A job description should be developed and the availability of [MRP Chair] positions advertised through the BCMA, the College, the UBC Faculty of Medicine. (Anyone who meets the qualifications should be able to apply.) It should be noted in the advertisement that the location of the applicant’s practice or the gender of the applicant would not preclude appointment as an MRP Chairman. However, willingness to serve in the Lower Mainland or Victoria should be specifically required…

Chairmen should have the following qualifications:

- broad knowledge, experience and training
- established clinical expertise and experience
- knowledge of occupational illnesses and diseases facility in the preparation of reports
- ability to act as a facilitator/coordinator proven leadership ability
- ability to assess clinical evidence and arrive at a judgment
- ability to acquire (and acquisition of) knowledge of the Workers’ Compensation Act and the MRP process
- demonstrated fair-mindedness, objectivity (not only being objective, but also being seen to be objective)
- a member in good standing with the College and licensed to practice in BC
- carrying CMPA or some other form of acceptable valid liability insurance
- willingness to commit necessary time to the MRP process, including attending Education Days.

Gallagher Report
Gallagher recommended that the Lieutenant Governor in Council should be encouraged to "establish, in writing, reasonable terms and conditions of appointments for Chairs and Specialists or candidates for appointment... The terms and conditions should include relevant roles definitions, limitations on jurisdiction, metes and bounds of independence, adherence to the departments goals, objectives, quality assurance measures and performance standards, and recognition of the sense of urgency which attends all cases coming before them.” He also recommended that any candidate for an Order in Council appointment should "agree to be bound by the specific terms and conditions of appointment, as a pre-condition to appointment or re-appointment..."

Registrar
Current Registrar Sheardown recently agreed that criteria for the appointment of panel members should be clearly articulated. She commented that the College of Physicians and Surgeons of BC and the BCMA would also prefer if clearly defined criteria were established for making the selection. The criteria could ensure, for example, that Specialists maintain a practice other than acting as a WCB consultant and that they be fully registered. The criteria could also address the need for higher standards relating to past conduct.
Discussion

Submissions in this area agree that criteria for the appointment of panel members should be established and clearly articulated. No arguments have been found to contradict this assertion.

Gallagher recommended that the LGC should establish the criteria. If so, it would be reasonable to expect the LGC to carry out this task in consultation with groups or individuals possessing a high degree of medical expertise. For example, “guidelines for this procedure [could] be developed by the Registrar, MRP and supported and approved by the Joint Medical Committee, Chairmen, MRP and the Board of Governors (Panel of Administrators) prior to final approval by the Lieutenant-Governor-in-Council.”

Generally speaking, the criteria could include some or all of the suggestions, as outlined by Gallagher and Sheardown.

Recommendations/ Options

It could be recommended that criteria for the appointment of panel members be established and clearly articulated.

The criteria could include some or all of the following suggestions, as outlined by Gallagher, Sheardown and the Medical Advisory Committee:

- knowledge of jurisdictional limitations and metes and bounds of independence;
- adherence to departments goals and objectives;
- adherence to quality assurance measures;
- adherence to performance standards (including standards of conduct);
- recognition of the sense of urgency which attends all cases coming before them;
- a preclusion against maintaining a practice other than as a WCB consultant;
- an agreement to be fully registered;
- broad knowledge, experience and training
- established clinical expertise and experience
- knowledge of occupational illnesses and diseases facility in the preparation of reports
- ability to act as a facilitator/coordinator proven leadership ability
- ability to assess clinical evidence and arrive at a judgment
- ability to acquire (and acquisition of) knowledge of the Act and the MRP process
- demonstrated fair-mindedness, objectivity
- a member in good standing with the College and licensed to practice in BC
- carrying CMPA or some other form of acceptable valid liability insurance
- willingness to commit necessary time to the MRP process, including attending Education Days.

It could be recommended that the LGC establish the criteria of in consultation with groups or individuals possessing a high degree of medical and other relevant expertise (e.g., the Registrar, the Joint Medical Committee, Chairs and the Panel of Administrators).

4. **Should the appointments of Chairs and Specialists be for a specified term? If so, what lengths?**

**Submissions and Reports**

**Jenkins Report**
Jenkins made the following recommendations regarding the term of appointment of MRP Chairs:

> Currently, appointments of Chairmen are without term. Chairmen should be appointed for a five-year term. 

**MRP Advisory Committee**
In 1992 the MRP Advisory Committee made the following recommendations in this area:

> MRP Chairmen should be appointed for five year terms but may be reappointed. (How to deal with existing appointments was discussed. For example, should existing MRP Chairmen be grandfathered? [This mechanism was not favoured by the Committee.] If not, should the terms be staggered to maintain some continuity and, if so, how? The Committee did not reach a conclusion on this point and will discuss it further at a future meeting.)

> Specialists should serve for five years and then be required to reapply.

**Gallagher Report**
Gallagher recommended that the Lieutenant Governor in Council should be encouraged to "implement five-year renewable terms for all Order-in-council appointments for Chairs and Specialists." He also recommended that terms of appointments of Chairs and Specialists should be staggered "to provide for continuity as some appointments end and new appointments are made."

**Registrar**
Current Registrar Sheardown recently agreed that panel members should be appointed for five year terms.
Discussion

All submissions and reports in this area are in agreement that appointments should be for a five-year term. No arguments have been found to contradict this recommendation.

[Jurisdictional comparison in progress]

Recommendations/ Options

It could be recommended that appointments of Chairs and Specialists be for a five-year term, that terms be staggered and that there be "grandfathering" for existing Chairs.

5. What criteria should be used the disqualification of Chairs and Specialists?

Submissions and Reports

Jenkins Report

Jenkins made the following recommendations regarding the termination of MRP Chairs and Specialists:

There should be a termination process for Chairmen, MRP. Guidelines for this procedure should be developed by the Registrar, MRP and supported and approved by the Joint Medical Committee, Chairmen, MRP and the Board of Governors, prior to final approval by the Lieutenant-Governor-in-Council.

The current list of disqualifications for Specialist Members serving on a given Panel is adequate. Other disqualifications should be included as they become apparent from experience. This list should be continually updated. For example, the current list of disqualifications for Specialist Members should include a preclusion for those Specialists who have previously served on a prior MRP involving the worker. Also, a preclusion may be necessary for Specialists who are related to physicians who have previously treated the worker. A Certificate has recently been declared null and void as a result of this relationship.

MRP Advisory Committee

In 1992 the MRP Advisory Committee made the following comments about termination of appointments:

An MRP Chairman should be terminated or not reappointed for "cause", which would include substance abuse impairing ability to conduct his or her duties,
incompetence, proven impropriety, loss of confidence by Specialists as a group, and ceasing to be a member in good standing with the College.\textsuperscript{70}

It might be helpful for the Advisory Committee to meet with the joint medical Committee to discuss the need for qualified Specialists and the problems which can arise from "poor choices."\textsuperscript{71}

\textbf{Gallagher Report}

Gallagher recommended that the Lieutenant Governor in Council should be encouraged to "terminate the appointment of a Chair who now resides outside of the province of BC" and "terminate Chairs and Specialists who have demonstrated that they are unwilling or unable to make sufficient time available to justify their names remaining on the rosters."\textsuperscript{72}

\textbf{Discussion}

Submissions in this area agree that a process and criteria for the termination of panel members should be established and clearly articulated. No arguments have been found to contradict this assertion.

It would be reasonable for the LGC to establish the process and criteria for termination in consultation with groups or individuals possessing a high degree of medical and other relevant expertise (e.g., the Registrar, the Joint Medical Committee, Chairs and the Panel of Administrators).

The criteria could include some or all of the suggestions, as outlined by Jenkins, Gallagher and the MRP Advisory Committee.

\textbf{Recommendations/ Options}

It could be recommended that a process for the termination of panel members be established and clearly articulated and that additional disqualifications be added to the current list.

The additional disqualifications could include some or all of the suggestions outlined by Jenkins, Gallagher and the MRP Advisory Committee -- i.e., preclusions for:

- panel members who have previously served on a prior panel involving the worker;
- panel members who are related to physicians who have previously treated the worker;
- panel members who have moved out of BC; and
- panel members who demonstrated an unwillingness or inability to make sufficient time to justify their names remaining on the roster.
Termination for "cause" could also be listed, including substance abuse impaired ability to conduct duties, incompetence proven impropriety, loss of confidence by Specialists as a group, and ceasing to be a member in good standing with the CPSBC.

It could be recommended that the LGC establish the process and criteria for termination in consultation with groups or individuals possessing a high degree of medical and other relevant expertise (e.g., the Registrar, the Joint Medical Committee, Chairs and the Panel of Administrators).

6. **Should there be renewal procedures for Chairs and Specialists?**

**Submissions and Reports**

**Jenkins Report**
Jenkins’ recommended that appointments of Chairs should be renewable.\(^{73}\)

**MRP Advisory Committee**
In 1992 the MRP Advisory Committee recommended that MRP Chairs should be reappointed after serving their five year term and that "Specialists should serve for five years and then be required to reapply."\(^{74}\) They also expressed the following concerns about such re-appointments:

> The process for reappointment may be more delicate. The question will be whether the particular MRP Chairman has maintained the necessary standards. It is not clear who should make the recommendation as to reappointment.\(^{75}\)

**Gallagher Report**
Gallagher recommended that the Lieutenant Governor in Council should be encouraged to "on a selective basis which reflects an objective and reasonable assessment of the demonstrated contribution made by existing Chairs, renew some existing OICs for one or three-year non-renewable terms, and the remainder for five years and subject to renewals."\(^{76}\)

He also recommended that the Lieutenant Governor in Council should be encouraged to "establish, in writing, reasonable terms and conditions of... candidates for...re-appointment. The terms and conditions should include relevant roles definitions, limitations on jurisdiction, metes and bounds of independence, adherence to the departments goals, objectives, quality assurance measures and performance standards, and recognition of the sense of urgency which attends all cases coming before them."\(^{77}\)

**Discussion**

Submissions in this area agree that there should be a clearly articulated renewal process for panel members. No counter-arguments have been found to contradict this assertion.
[The jurisdictional comparison may assist the Commissioners in making this decision]

**Recommendations/ Options**

It could be recommended that criteria for the appointment of panel members be established and clearly articulated.

The criteria could include some or all of the following suggestions, as outlined by Gallagher:

- relevant roles
- definitions;
- jurisdictional limitations;
- metes and bounds of independence;
- adherence to departments goals and objectives;
- adherence to quality assurance measures;
- adherence to performance standards (including standards of conduct);
- recognition of the sense of urgency which attends all cases coming before them;

It could be recommended that the LGC establish the criteria of in consultation with groups or individuals possessing a high degree of medical and other relevant expertise (e.g., the Registrar, the Joint Medical Committee, Chairs and the Panel of Administrators).
C. NUMBER OF ACTING MRP CHAIRS AND SPECIALISTS

Summary of Issue

The Royal Commission has heard from a variety of sources that there are insufficient numbers of Chairs and Specialists available to serve on MRPs. This has been an ongoing problem for several years.

For example, Gallagher commented that "the number of Chairs and Specialists is a matter which should be examined more closely..." His analysis was as follows:

*In my view, the existing complement of Chairs and Specialists can handle no more than 450 to 500 examinations per year. Even at that level the administrative staff would face difficulties in scheduling examinations, given the limited time slots that Specialists are prepared to make available. If the present level of new case intake continues, with the prospect of reaching 650 - 700 in 1996, it will be necessary to add considerable capacity to the rosters from which panels are drawn.*

Because the Chairs and Specialists are paid only as and when they are scheduled for panel participation, the cost of maintaining greater capacity would increase only in relation to the costs of recruiting, training and maintaining communications with the additional physicians.

More recently, it was acknowledged in the 1998 MRP Department Business Plan that "the availability and willingness of physicians to serve on Medical Review Panels has a direct impact on our ability to provide service." It was also stated that, as a "critical success factor," the MRP Department "must develop a liaison with the Ministry of Labor to ensure that the list of Chairs and Specialists remains current and functioning."

For greater clarity, the availability of Specialists and Chairs have been examined as separate topics below:

1. Number and Availability of Specialists

Summary of Sub-Issue

It appears that the number of available Specialists has been decreasing in recent years. In 1994, Weldon Brake noted that there were 208 Specialists with 24 specialties eligible to serve on MRPs (43 outside the Lower Mainland).

In the 1996 MRP annual report, it was noted that “in 1996 there were 175 Specialists available listed from 24 areas of medical expertise.”

Medical Appeal Officers and MRP Administrative Staff recently told the Royal Commission that it has been approximately two years since new names were added to the list of Specialists, that the situation is "grim" and that there is a need to place more Specialists on the list. It was explained that some doctors are unavailable, or on
vacation, or sometimes the doctors have different days available during the week so that it is impossible to schedule a panel using certain doctors. This means that certain specialties may be unavailable on a particular panel.

**Submissions and Reports**

**Jenkins Report**

Jenkins made the following recommendations to encourage the maintenance of Specialist appointments at an adequate level:

> There needs to be a constant updating of the list of available Members for the MRP. The number of selected Specialist Members in a given specialty is not always adequate. Constant updating would reduce any delays due to scheduling of available Specialists.

> Physicians and surgeons in B.C. should be adequately notified of the opportunity to become a Specialist Member of the MRP.

> Delays in the process have been identified due to Specialists’ unavailability. The specialties in which this occurs should be identified on an ongoing basis and in consultation with the medical committee, and rectified as soon as possible by additional Specialists being named. The Registrar should be responsible for seeing that this is done.

> The Specialist lists should be updated on a regular basis.

> The medical committee should meet on a regular basis and maintain the listing of specialty members at an adequate level, as advised by the Registrar.

In 1992 the MRP Advisory Committee made the following recommendations to encourage the appointment of qualified MRP Specialists:

> The sections of the BCMA and the departments of the UBC Faculty of Medicine should be notified of the availability of MRP Specialist positions and asked to submit names to the joint medical committee. If the joint medical committee refuses a Specialist put forward by a section or a medical department, the reasons for the refusal should be documented in its minutes.

> A job description should be developed as it pertains to MRP duties and responsibilities and the availability of [MRP Specialist] positions advertised through the BCMA, the College, and the UBC Faculty of Medicine.

> A survey should be conducted among Specialists to determine why more do not apply to become MRP Specialists.
Gallagher Report
Gallagher explained why Specialists are frequently unavailable:

While some of the Chairs are semi-retired or retired from practice, the Specialists are still actively engaging busy practices and can only make a limited number of time slots available for MRP examinations. This means that for each and every MRP file, a member of the administrative staff must arrange a time and date which will suit the calendars of three external physicians. Very often the times in dates must be subsequently rescheduled. For the administrative staff, this is a very time-consuming and frustrating process.  

He recommended that the Lieutenant Governor in Council should be encouraged to "take a more aggressive and proactive role in working with the Medical Committee, to ensure that adequate numbers of registered Specialists are recruited to meet the need for panel appointments."

Discussion
Submissions are in agreement that there are not enough Specialists to meet current needs.
No arguments have been found to contradict the assertion that more Specialists should be hired.
The measures proposed by Jenkins and Gallagher appear reasonable.

[Note that the Royal Commission has been told by MRP Registrar Sheardown that a report is being prepared which tracks implementation of Gallagher's and Jenkins' recommendations. This report will presumably clarify precisely which (if any) of the above recommendations have been implemented]

Recommendations/ Options
It could be recommended that more Specialists be hired.
Depending on Sheardown's report, it could be recommended that all or some of the following steps be taken:

- lists of available Specialists could be updated on a regular basis;
- eligible physicians and surgeons could be regularly notified of the opportunity to become a Specialist;
- specialties which are more commonly unavailable could be identified on an ongoing basis and additional Specialists could be named in those areas;
- the BCMA and the UBC Faculty of Medicine could be notified regarding availability of MRP Specialist positions and asked to submit names to the joint medical committee; and
- a survey could be conducted among Specialists to determine how to attract more MRP Specialists.
2. Number and Availability of Chairs

Summary of Sub-Issue

The number and availability of Chairs has also been declining in recent years. In 1994, Weldon Brake noted that, "as of the end of November 1994 there were 15 part-time Chairmen." At the time of Gallagher's report there were 15 Chairs. He recommended that the Lieutenant Governor in Council should "increase in the numbers of Chairs from 15 to 22." The Royal Commission was recently told by MRP members and staff that there are currently 13 Chairs, 11 of whom are acting. The majority are retired or semi-retired and approximately half of the Chairs are over 70 years old.

MRP Advisory Committee
Dr. Ian Connell of the MRP Advisory Committee argued that Chairs are never lacking for panels, although it is very hard to schedule such panels, given that needs are sporadic.

Current and Former Registrars
Current Registrar Sheardown agreed that there is definitely a need for new Chairs -- perhaps 5 more. She predicted that the existing Chairs would say that they can handle the work, but said the scheduling clerk would disagree. She stated that the either the new Chairs should be required to make a commitment regarding their availability, or the list could be made long enough to accommodate the back-fill.

Former Registrar Martin recently commented that 11 Chairs is clearly not an adequate number.

Discussion

There is agreement that there is a need for more Chairs. This problem appears to stem from several source:

- a lack of commitment on the part of Chairs regarding availability; and
- inertia in replacing Chairs who resign or are not active.

Recommendations/ Options

It could be recommended that more Chairs be hired. As well, could be recommended that one or both of the following steps be taken:

- new Chairs could be required to make a commitment regarding their availability; and
- the list of Chairs could be made long enough to accommodate back fill.
D. **Narrative Reports Prepared by MRPs**

**Summary of Issue**

Jenkins has offered the following explanation regarding the content of the Narrative:

> The Narrative Report is compiled and prepared by the Chairman of the MRP. It accompanies the MRP Certificate. It is a detailed document summarizing and focussing on the data provided by the board with regard to the file information, the detailed findings of the history-taking and physical information. It will sometimes contain sensitive personal medical information recommending a form of action beneficial to the worker’s condition.\(^98\)

The following problems have been associated with the Narrative:

- The purpose of the Narrative report has not been sufficiently or clearly defined.
- The Narrative has been inappropriately used to provide reasons for, justify or supplement a Panel’s decision.
- Panel members have not received adequate training regarding the production of the Narrative. As a result, Narratives may be excessively long, produced in the wrong format, unclear, incomplete or may deal with irrelevant matters.

Gallagher recommended the elimination of the Narrative entirely. Others, such as Jenkins and members of the MRP Advisory Committee have recommended maintaining it but taking steps to correct the problems identified above through clarification and training.

**Law & Policy**

An MRP’s authority to provide a “Narrative report” is derived from s.61(2) of the Act:

> The panel may, in addition to and separately from the certification required under subsection (1), make a report and recommendations to the board on any matter arising out of the examination and review, and the board must promptly send a copy of them to the physician whose certificate was sent to the board under section 58(3) or (4)”.

Published WCB policy further defines the nature and purpose of the Narrative report:

> Section 61 (2) of the Act provides that the Panel may, in addition to and separately from the certification required under Section 61(1), make a report and recommendations to the Board on any manner arising out of the examination of the worker and the review of the medical records. The recommendations, even if they deal with medical issues alone, are not binding on the Board. Where the Panel does make such report the Board shall promptly send copy of the report to the physician who certificate was sent to the Board under Section 58(3) or 58(4).
Given the context in which Section 61(2) appears, it is the Board’s opinion that the primary purpose of a Narrative report is to bring to the attention of the physician who provided the certificate under sections 58(3) or 58 (4) matters of medical interest which “go beyond that required to be certified to in the certificate.” The purpose of the Narrative report, when one is prepared, is not to justify the conclusions that the Panel has in its certificate.

The Narrative is usually 4 to 6 pages long although some may be as long as 30 pages. A longer Narrative may delay issuing of the Certificate. While the decision is often made on the same date, the report generally takes longer to complete. There is no cap on billing for Narratives.

Submissions and Reports

Jenkins Report

Jenkins offered the following recommendations on the topic:

1. The purpose of the Narrative Report should be more clearly defined. Guidelines for the format of the Narrative should be developed by the Registrar, in consultation with the Chairman, in order to insure consistency and completeness. It is important that this guidance be seen not as legislation, but as facilitation.

2. Procedures for clarification of contradictions with the Certificate should follow the process outlined in Recommendations VII-5.6. [i.e., “Ideally, the need for clarification of Certificates should be eliminated by the improvement in the quality of a Certificate, e.g. no ambiguity, no contradictions, no inconsistencies, not beyond the Panel’s jurisdiction, no errors made, and no new consideration of new non-medical factual evidence...”].

3. The Narrative Report should be required in association with the Certificate. The Act does not specify that a Narrative Report is legally binding. In fact, the Act does not state that a Narrative Report is required from the Panel.

4. The Narrative Report should not be used to provide the reasons for the Panel’s decision. The reasons should be included in the Certificate, as it is the binding document...

5. The Narrative Report should not include an explanation as to why the Panel disagrees with conclusions of other doctors who have provided opinions on claim. Inclusion of reasons for the decision... would provide these other doctors with feedback as to why the Panel has disagreed with their medical conclusions.

6. There should be continued discretion in distribution of the Narrative Report in view of possible personal and sensitive medical information being present in the report. Compliance with [the Freedom of Information and Protection of Privacy Act] should be undertaken.
**Gallagher Report**

Gallagher recommended that the routine preparation of a Narrative report by MRP’s should be discontinued, based on the following observations:

*In some cases the Narrative is as long as 30 pages... They result in time delays since a case file is not being advanced while a Narrative is being written (sometimes a matter of weeks). There are significant related costs since the physician-adjudicator is charging for the time involved. The Narrative serves no useful purpose for the MRP department or the Board. It is the certificate issued by the panel which is binding on the Board. And if there are conflicts or inconsistencies between the language of the certificate and Narrative, the affected parties are quick to use the information to challenge the validity of the certificate. (I am aware that there are opposing views held by representatives of workers; however, I am not persuaded to alter my own views by the arguments that have been made to me).*

A legal opinion provided to former MRP registrar David Martin has determined that discontinuance of the routine preparation of Narrative reports would withstand judicial review for the following reasons:

*...the production of such a report is entirely at the discretion of the panel. Only the certificate is mandatory, and pursuant to section 65, only the certificate is conclusive and binding on the Board. The scope of the Narrative report contemplated by the Act is clearly intended to go beyond the specifics of the certificate because section 61(2) provides that the panel may "make a report and recommendations to the Board". In my opinion, one logical interpretation of the purpose of the Narrative report is to provide assistance to the Board in adjudicating the claim. While the Narrative report may not justify conclusions in the certificate, it may help explain the conclusions reached in the certificate. The report may involve recommendations regarding further medical treatment of the worker. Such recommendations would not be binding on the Board. The Board would treat the opinions contained within the Narrative report like any medical opinion to assist it in adjudicating claim."

**MRP Advisory Committee**

Dr. Connolly recalled that the need for the Narrative was debated and it was decided that it is necessary in order to give a background and to give reasons for certificate decisions. He remarked that the Narrative is very helpful and necessary, given that the certificate is not explanatory and that it is sent to the doctor who prepared the enabling certificate, who can help the worker interpret the certificate. In other words the Narrative aids in future understanding between the worker and his or her doctor.
Medical Appeal Officers and MRP Administrative Staff
The Royal Commission was told by MAO’s and MRP administrative staff that the following problems have been associated with Narratives:

- Doctors often produce the Narrative report in the wrong format.
- They wrongly use the Narrative report to justify the certificate, so it becomes hard for the certificate to stand alone.
- The Narrative is inappropriately used to supplement the certificate.

Gallagher Report
Gallagher asserted that:

- Some physician adjudicators have unacceptably long turnaround times for certificates.
- Written Narratives produced by some MRP chairs are excessively long.
- Some certificates are unclear, incomplete, or deal with irrelevant matters.

Current and Former MRP Registrars
Current MRP Registrar Sheardown and former MRP Registrar Martin identified the following problems with the Narrative:

- The Narrative is often more problematic than helpful because it is often difficult for the MRP department and Registrar to keep to pertinent information within the certificates.
- Narratives sometimes digress into areas deemed non-medical
- Doctors are often unaware of FOI (i.e., that the claim file may fall into the hands of the worker) and some have a hard time keeping it pertinent and non-personal.
- They may leave out some information or they may miss a date causing claimants to object, despite the fact that the Narrative is not binding.

Despite these criticisms, former MRP Registrar Martin acknowledged that the Narrative can be extremely useful, even though the Narrative is "detested" by some. In support of the Narrative, Registrar Sheardown asserted that, if workers and claimants were simply getting a Certificate without a Narrative, this would open up requests for background information.

Discussion
While all submissions on the topic identified problems with the Narrative, only Gallagher recommended its elimination. Some submission identified valid reasons for its retention. For example, it appears to provide a useful background and aids in future understanding between the worker and his or her doctor. As well, none of the problems identified in submissions and reports appear insurmountable. For example:
The purpose of the Narrative report could be clearly defined in the Act.
Panel members could be required to take training regarding the production so that it is not excessively long, produced in the wrong format, unclear, incomplete and does not deal with irrelevant matters.
It could be clarified that the Narrative should not be used to provide reasons for, to justify or to supplement a Panel's decision.

Recommendations/ Options

It could be recommended that the Narrative be eliminated entirely.

Alternatively, it could be recommended that the Narrative be continued, but that steps be taken to correct the problems which have been identified above. Such steps could include:

- clearly defining the purpose of the Narrative in the Act;
- providing Panel members with training regarding the production of the Narrative;
- clarifying that the Narrative should not be used to provide reasons for, to justify or to supplement a Panel's decision; and
- ensuring that claimants understand the purpose of the Narrative.
E. ROUTINE PREPARATION OF THE STATEMENT OF NON-MEDICAL FACTS

Summary of Issue

The role of the "Statement of Foundational Non-medical Facts" ("SFNMF") by the WCB has been an ongoing topic of debate. The three options which have been put forward are as follows:

- discontinue preparation of the SFNMF;
- prepare the SFNMF only in complex or difficult cases; or
- routinely prepare the SFNMF in all cases.

The discussion below examines arguments in support of each of these options.

Law & Policy

Section 64 of the Act provides as follows:

Where the board or the Panel considers that a statement of foundational non-medical facts is necessary to determine the medical dispute, the board must prepare and deliver the statement to the Chair of the Panel for the use of the Panel.

The following policy regarding the SFNMF is found at #103.60 of the RSCM:

Where the Board considers the statement of foundational non-medical facts is necessary to determine the medical dispute, the Medical Review Panel Department will prepare such a statement for the Panel. It is expected that only in unusual cases or where the request is under section 58(5) and there is no physician’s certificate would such a statement be necessary.

When The Panel, after receiving the statement of issues, with appendices, considers the statement of foundational non-medical facts is necessary to determine the medical dispute, the Panel shall advise the Medical Review Panel Department what non-medical facts require determination in order for it to determine the medical dispute, and the Medical Review Panel Department will prepare such statement.

The Statement of Issues, and the statement of foundational non-medical facts when one is required, will be sent to the parties participating in the appeal for comment prior to being sent to the Medical Review Panel Chairman.

When there is a dispute regarding the contents of either document a Medical Appeals Officer will attempt to resolve the dispute. If this is not satisfactorily resolved the Registrar will, upon written request, review the Statement of Issues and/or the statement of foundational non-medical facts and make a final
determination as to the contents of these documents. The appeal will then proceed to the Medical Review Panel.

Because the decision of the Registrar as to the contents of these documents has no bearing on whether the matter proceeds to The Medical Review Panel, the Board considers this decision to be administrative decision and it cannot be appealed to the Review Board.

The administrative nature of the decision refers only to the Medical Review Panel Department’s authority to include or exclude already decided facts in the statement of foundational non-medical facts.

If the Medical Review Panel Registrar or Medical Review Panel identify, in order to determine the medical dispute before the Panel, the need for a decision on the non-medical fact that has not been decided by the Board, the Registrar will refer the issue to the Compensation Services Division of the Board for adjudication by the appropriate Board officer (e.g. Claims Adjudicator, Claims Adjudicator Disability Awards, etc.).

A decision will be communicated to the interested parties in the normal way, and being a new decision with respect to a worker, if there is a dispute there will be a right to appeal the decision to the Review Board pursuant to Section 90 of the Act. The Medical Review Panel process will await resolution of the dispute before proceeding further.

Given that, under Sections 58(3) and 58(4), the Medical Review Panel process requires a physician’s certificate that certifies as to the existence of a bona fide medical dispute and that provides sufficient particulars to identify the issue before the Medical Review Panel process can proceed, and that most Medical Review Panel appeals have already been through the Review Board and Appeal Division appeal process, is expected that the need to make new findings of non-medical fact after the Medical Review Panel process has begun, will occur only on rare occasions.

Submissions and Reports

Jenkins Report
In 1992, Jenkins recommended that the SFNMF should be prepared in every case:

In order to focus on the facts and issues in an accurate, efficient, organized, and consistent manner, it is necessary for the Board to continue to prepare a Statement of Foundational Non-Medical Facts/Issues in every case. It provides a non-medical background and gives the Panel an outline of the facts that led to the issue being appealed.

Brake Report
In 1994, the SFNMF was being prepared in all cases by Medical Appeal Officers. At that time, Brake explained that "the preparation of the SFNMF is an issue of
considerable debate within the MRP Department, the MRP Chairman and the Community.” The cause of this debate related to the fact that the SFNMF was considered to be a major cause of delays in the MRP system. At that time, 53 percent of the total time from initiation Appeal to implementation of a decision was required for its preparation.

At that time, Brake recommended preparation of the SFNMF in all cases, but in a "modified”, “more comprehensive and less detailed” fashion. It was decided that Advisory Committee members would use a "Case History" format on a trial basis, in conjunction with a modified SFNMF. The objective was to obtain feedback from three Selected MRP Chairs to determine which system would be preferable.

1995 Annual Report
In 1995 the decision was made by Brake to discontinue regular preparation of the SFNMF. The 1995 MRP annual report elaborates as follows:

The practice of the Department to prepare a Statement of Foundational Non-Medical Facts in all cases was changed. Instead, a Statement of Issues asking the medical questions that the Board wants the Panel to answer is prepared. Appended to this Statement of Issues is the physician’s certificate and the Board decision or finding in dispute. The Board and the Panels retain discretion to determine if a Statement of Foundational Non-Medical Facts is necessary under Section 64 of the Act.

Administrative Inventory
The following explanation was offered in the 1995 administrative inventory: In the hope of speeding up the entire process, the policy was changed in May 1995 to end the practice of regularly preparing a statement of non-medical facts. In the future this will be done only in “unusual cases.” The measure has enabled the Medical Review Panel Department to reduce a number of Medical Appeals Officers from six to one.

Gallagher Report
In 1996, Gallagher emphasized that he was not recommending reintroduction of the production of the SFNMF in every case. However, he did comment that "the decision to eliminate [the statement] should have been given more thought” He therefore recommended "further careful study.” He elaborated as follows:

There is no doubt that the production of the Statement was a labor intensive task... I do not argue with the proposition that the routine production of the Statement may prove to be important step in streamlining the MRP processes... And over a longer period of time, discontinuing the routine production of the Statement will translate to the need for fewer MAOs... But there are other considerations.

The statement was produced to insure that the MRP’s had before them the information they are required by the Act to consider when they are conducting
the medical examinations. The Act limits the adjudicative role of the MRPs to being finders of medical facts. Their narrowly defined jurisdiction is to resolve the bona fide medical dispute which is presented to them in the form of questions prescribed by the Act. They are not finders of non-medical facts, and they have no jurisdiction to alter the findings of non-medical facts that have been made by others in the compensation system.

How then are the MRPs to determine what the relevant non-medical facts are? Section 60 of the Act requires the Panel to conduct a "... review of the record..." as well as examine the worker whose claim is the matter from which the MRP application springs. It is my view that the "record" is the entire compensation claim file. The Act contemplates that the Panel is to have regard for all the findings of non-medical facts that have been made in response to the claim. In the absence of a prepared Statement, the Panels are left to choose between alternative courses of action in order to have regard for the non-medical facts:

They can review the entire file to acquaint themselves with the findings of non-medical fact. This may be a simple step in some cases, requiring no more than reading a claims decision, a decision of the Appeal Division, or the findings of the Review Board. However, in many cases it will mean reading all three or combinations thereof. And some of the cases "files" are in reality a veritable mountain of hard copy materials contained in a box.

Two questions arise: are the MRP’s adequately trained as adjudicators to know what findings of facts are relevant? Without doubt, some are; however, there is clear evidence that some are not. Within the context of the compensation system, the consequences of framing a medical decision with the wrong non-medical facts can be very serious. Does it make sense to save time at the level of administrative staff only to pay a physician more than $140.00 per hour to ferret out to the non-medical facts that they are expected to have regard for? There is evidence that the elimination of the Statement has resulted in an increase in the cost associated with some MRP examinations.

The other course of action available to the MRPs is that they can, as they are trained to do and routinely do in the course of their own practices, take a patient history from the worker. Such history would include the worker’s representations about non-medical facts relating to the compensation claim. Those representations may be at odds with findings of non-medical facts that have been made within the compensation system - findings of fact that are binding on the MRPs and which they have no jurisdiction to make or alter. If, in arriving at their determinations, the MRPs have regard for any non-medical “facts” which are outside of their jurisdiction, and at odds with the facts on the file, they are exceeding their jurisdiction. The costs to the compensation system could well be substantially more than the costs of producing the Statement on each file.112

**MRP Advisory Committee**
It was recently confirmed by the MRP Advisory Committee that Panel members no longer routinely receive the SFNMF -- although they do if the facts are complicated. In
most cases the Panel members rely on non-medical facts contained in previous appeal decisions. One MRP Advisory Committee member commented that the SFNMF is somewhat helpful, but not necessary, because Panel members must review the entire file in any case since they cannot depend on another person's interpretation. MRP Advisory Committee members were asked what would occur if the "facts" differ, for example if the workers' history conflicts with the claim file history. Dr. Ian Connell responded that, if the matter was significant, it would be sent back to the MAO to be sorted out. As well, he stated that it is often helpful to request the workers' medical history in order to shed light on what actually happened.13

Medical Appeal Officers and MRP Administrative Staff
Medical Appeal Officers and MRP Administrative Staff recently gave the following description of the current practice in this area:

- Panel members liked the SFNMF. It made their job easier, since both parties had seen the statement and had accepted it. Despite this, there has not been much controversy surrounding the fact that routine preparation of the SFNMF was discontinued in 1995. This may be due to a lack of understanding on the part of the Panel Members.

- MRP's sometimes make findings of non-medical facts which are at odds with the facts found in the claim file. For example, if an injured worker claims that he fell 20 feet, when in fact he only fell 10 feet, the Panel will generally not go back to the file or the WCB to try to establish this non-medical fact. The Panel will simply deal with the medical issues.

- An MRP can refer an issue back for determination of a non-medical fact, but this is uncommon.

- Because most MRP exams follow appeals from the Appeal Division and WCRB, non-medical facts are generally clearly established by the time the matter reaches the MRP stage. Non-medical facts found by the last appeal body (i.e., the Appeal Division) are accepted.114

Current and Former MRP Registrars
Current and former MRP Registrars offered the following perspective:

- SFNMFs are not being prepared very often, but rather in particularly complex cases.

- Chairs never ask for an SFNMF in specific cases, although in many cases more medical information must be requested.

- Elimination of routine preparation the SFNMF did not actually speed up the process because downsizing of the number of MAOs occurred at the same time. Since there were only 2 MAOs instead of 7, there was no longer a production engine.
- MAOs will agree that they have to do some file review in any case, so it does not add that much time to produce the written summary of their file review as an SFNMF.

- The fact that the SFNMF was an appealable decision caused some confrontations in the past. Workers could confront doctors with established facts at that point. Some physicians don't like confrontation. But now, by not having the facts debated and appealable, doctors may feel they are being put in the position of having to decide or determine the non-medical facts themselves. Doctors are starting to realize that this is problematic, particularly since Panels may be confused about what constitutes a non-medical fact.

- It may be that the SFNMF should be re-implemented. If a decision has come directly from the WCB and there is no appeal, it would be helpful for the Panel to have the statement of non-medical facts. This is because the Panel does not have the appeal decision to look at, which generally summarizes the facts. It might be necessary to re-institute the SFNMF where there is no previous decision/appeal to look at.\(^\text{115}\)

**Stakeholder Counsel - Steeves**

Steeves was asked whether he saw any room for improvement to the current the approach to SFNMFs. He responded that:

> I think we are basically content with the current system... The advantage to the previous SFNMF was that it did give another crack at setting out the record... rather than just stapling the decision under appeal to the Statement of Issues... .

> –Now, that opportunity has been lost. But...what’s been gained is relative speed... I’d guess there are fewer appeals to the Review Board on threshold issues for Medical Review Panel\(^\text{116}\)

**Discussion**

It is clear from submissions and reports that the SFNMF is necessary where cases are complex or where the non-medical facts have not been clearly established (i.e., where there has been no previous appeal decision).

There are also compelling arguments for the reintroduction of the routine preparation of the SFNMF. Submissions are generally in agreement that its routine preparation was helpful to Panel members in the past. The main reasons for eliminating this policy was to expedite the process and to reduce the number of MAOs. However, both of these justification are questionable, for the following reasons:

- As will be discussed later in more detail, the decision to reduce the number of MAO actually contributed to delay and backlog problems and was subsequently reversed.
- The current and former Registrars have stated that production of the SFNMF does not actually consume much extra time because MAOs conduct a file review in any case.

As well, there are valid reasons for assigning this task to trained individuals other than Panel members:

- Elimination of the preparation of the SFNMF has encouraged Panel members to make findings of non-medical facts which may contradict the findings of fact in the claim file.
- The determination of non-medical facts is outside the jurisdiction of Panel members.
- The determination of non-medical facts is beyond the expertise of Panel members.
- Panel members’ time is expensive. It makes more sense from an economic perspective to use MAOs or other trained staff.

**Recommendations/ Options**

It could be recommended that production of the SFNMF should continue in complex cases or where non-medical facts have not been clearly established (i.e., where there has been no previous appeal decision).

Reintroduction of the routine preparation of the SFNMF by trained individuals other than Panel members could also be recommended. If so, and it is also recommended that the MRP process be integrated with an independent appeal process, it could be recommended that staff from that appeal authority carry out the function.
F. **UPDATING THE MRP DEPARTMENT COMPUTER SYSTEM**

**Summary of Issue**

There is a consensus that the current computer information system in the MRP Department should be updated.

**Submissions and Reports**

**Weldon Brake**

Brake commented that a Development Service Proposal for the new MRP computer system was approved in November 1, 1994 and that funds were approved for the new system in the 1994 -- 1995 budget. Its stated purpose would be to "track and manage all information and processes relating to each MRP file" including the following:

- track all information relating to the overall MRP process;
- track all requests for examination by Medical Review Panels;
- track all assignments of appeals to Medical Review Panels;
- maintain a list of "contact parties"; and
- report MRP information to the Board Governors.  

**Gallagher**

Gallagher stated that "The MRP department does not have the benefit of an effective case management system." Its computerized system is so "ineffective" and "obsolete" that "it hinders the efficient processing of cases." The need for an up to date system is "urgent." He concluded that such a system could:

- electronically monitor the progress of case files;
- measure time lapses;
- provide flags to time limits;
- call attention to delays; and
- provide management tools (e.g., re: caseload statistics, performance measurements, mail-merges, scheduling).

**1996 MRP Annual Report**

The following was noted in the 1996 MRP annual report:

> Technologically, the Medical Review Panel Department is out of step. The Appeals Management System which is being used is 12 years old. A total system rebuild has been rejected on the following grounds:

- Cost
- Lack of availability of technical staff in Information Systems Division
- Old work processes in place within Medical Review Panel Department
- Impending Royal Commission
Instead the Department has taken action and decided on a strategy of maintaining productive capacity using the present system while adopting a parallel strategy of process review and improvement.

The Department contracted with two small consulting firms to;

1. Carry out an analysis of the technical system and process generally.
2. Carry out a small reengineering project designed to eliminate inefficiencies.

The first of the above actions was completed in early December 1996. Based on the analysis, the decision was made to proceed and try to improve the work process rather than rely solely on a technical or systems fix. Technology would be introduced where the introduction would be cost effective and immediate in impact. Two specific software packages have been identified and will be introduced in the second quarter of 1997. The process review is underway, with process review teams identified and completion schedules designed. May 1997 will see completion of the process work and an introduction of Payment and Scheduling software. This should alleviate two major areas of bottleneck. The goal is to do away with file hand offs and duplication of effort and to build an accountable system capable of maintaining customer service.

Current and Former MRP Registrars
In 1997, former Registrar David Martin acknowledged that a poor information management computer system is a continuing problem, but concluded that the MRP Dept should wait until the Royal Commission has been concluded and reforms of the entire appeal process have been completed, so that process inefficiencies are not replicated with systems technology.

It appears that, a degree of upgrading has taken place in the last few years. However, at a 1998 meeting of current and former registrars, it was acknowledged that the computer system in use now was built in 1986 and that, although the system functions well in terms of daily work, it is inadequate in terms of generating statistics, which must be done using a hand count.

MRP Department 1998 Business Plan
It was noted in the 1998 MRP Department Business Plan that "The information system is in need of overhaul or rebuilding. The department's computers have been substantially upgraded and the department is poised, with minor alterations, to except e-file."

"Our general facilities include workstations and PC terminals for every staff member. These have been substantially upgraded and the upgrading will continue in 1998." "The e-file project will begin to have a minor impact on the Medical Review Panel Department in 1998. The computer upgrades necessary have been considered and planned."
It was also noted that redesign of the MRP business processes in 1997 "did not include enhancements for the replacement of the mainframe Appeals Management System ("A.M.S."). Further analysis is required to determine changes to this legacy system."^22

**Discussion**

Clearly some updating is required. The argument that the MRP Dept should wait until the Royal Commission has been concluded and reforms of the entire appeal process have been completed will become inapplicable shortly.

**Recommendations/Options**

It could be recommended that the computer information system for the MRP process be updated to ensure that it has the ability to:

- track all information relating to the MRP process;
- track all requests for examination by MRPs;
- track all assignments of appeals to MRPs;
- maintain a list of "contact parties";
- report MRP information to the Board Governors/Panel of Administrators;
- electronically monitor the progress of case files;
- measure time lapses;
- provide flags to time limits;
- call attention to delays; and
- provide management tools (e.g., re: caseload generation of statistics, performance measurements, mail-merges, scheduling).
G. Ensuring Communication and Feedback for Panel Members:

**Summary of Issue**

It has been submitted that MRP members have not been sufficiently or consistently informed about administrative matters and various substantive issues (e.g., decisions of other panels, relevant medical developments, etc.). It has been recommended that communication and feedback be improved for this purpose, as between the following groups:

- **MRP Chairs and Specialists**
  (regarding common issues, decisions of other panels);

- **MRP's and MRP department administrative staff**
  (regarding administrative concerns); and

- **The WCB and MRPs**
  (regarding implementation of MRP decisions and relevant appeal decisions).

**Law & Policy**

Current mechanisms for ensuring communication and feedback between these groups are found primarily in non-published and unwritten policies. Several of these mechanisms were described to the Royal Commission:

- **Medical Appeal Officers and MRP Administrative Staff**
  The Royal Commission was informed by Medical Appeal Officers (MAO’s) and MRP administrative staff that feedback is given to Chairs once every six months or once per year and that the last time was a year ago. They also commented that Chairs can inquire at any time respecting specific questions and observed that they often do so.¹²³

- **Current and Former MRP Registrars**
  At a meeting of current and former MRP registrars, the Royal Commission was told that MAOs and Chairs communicate with each other periodically, in an informal fashion. For example, they communicate over the phone or on educational days, which occur approximately every six months. As well, the Royal Commission was told that the Chair may have a meeting with the Specialists after an MRP medical exam.¹²⁴

- **MRP Advisory Committee**
  Dr. Ian Connell of the MRP Advisory Committee recently described the role of the Medical Advisory Committee (MAC) in promoting communication between panel members and the MRP department. He said that the MAC includes 4 Chairs, that the Registrar acts as Chair of the committee and that the MAC acts as liaison between panels and the registrar. The meetings are recorded and eventually sent to all Chairs. Dr. Connell commented that, while the MAC is
supposed to meet quarterly, they have not met regularly in the past because the Registrar has had other priorities.\textsuperscript{125}

\textbf{Submissions and Reports}

\textbf{Jenkins Report}

Jenkins made the following observations regarding communication and feedback for Panel members:

- \textit{There should be a process for bringing together, from time to time, the MRP Chairmen to discuss common issues. The should be done at least every six months. Staff members of the MRP Department should attend the sessions.}
- \textit{There should be a process for advising the MRP Chairmen as to the implementation results of their own Panel and of the examinations of other MRP’s. The Chairmen should be kept generally informed to the decisions of other Panels. This should be coordinated by and be the responsibility of the Registrar, MRP.}
- \textit{The MRP Chairmen should be provided with copies of Court decisions and Appeal Division decisions issued with respect to the MRP process on an ongoing basis.}\textsuperscript{126}

\textbf{Gallagher Report}

Gallagher’s description of the day-to-day relationship between Panel members and MRP administrative staff sheds light on some of the underlying causes of communication and feedback difficulties:

\begin{quote}
The MRP department’s administrative staff and physician-adjudicators (physicians who serve as Chairs and Specialists-examiners) are not closely knitted into the day-to-day affairs of the MRP department; they conduct medical examinations on an assigned-file basis, as and when they are required. The Chairs and Specialists do not routinely work within, or out of, the same premises as the administrative staff - some are never seen within the MRP offices. The medical examinations are never conducted within the MRP’s facilities. Typically, and MRP examination is conducted in a physician’s examining room which has been arranged and scheduled for the specific case.\textsuperscript{127}
\end{quote}

\textbf{MRP Department 1998 Business Plan}

A stated strategy in the MRP Department 1998 Business Plan is to \textquotedblright\textit{improve level of support provided to MRP members through better communication\textquotedblright} by reviewing and clarifying the role of MRP members with the physicians.\textsuperscript{128} The action plan for this strategy includes the following:

- \textit{"Conduct workshop with MRP Chairs and produce report; [and].}
- \textit{Send monthly update to MRP Chairs.}\textsuperscript{129}
Options/Recommendations

It could be recommended that MRP members be consistently and thoroughly informed about relevant administrative matters and substantive issues.

Improved mechanisms for promoting communication and feedback between MRP Chairs and Specialists, between MRP’s and between MRP department administrative staff and the WCB could be outlined in regulation or published policy.

Jenkin's recommendations could be made mandatory:

- MRP Chairs should be required to meet to discuss common issues at least every six months. Staff members of the MRP Department should be required to attend.
- There should be a mandatory process for advising the MRP Chairs regarding decisions and implementation results of all MRP panels.
- MRP Chairs should be provided regularly with copies of all relevant Court decisions and appeal decisions.
H. **ENSURING COMMUNICATION AND FEEDBACK FOR APPELLANTS**

**Issue:**

It has been submitted that a brochure describing the MRP process should be made available for workers and employers.

**Current Approach**

Current brochures and information packages published by the WCB describing the appeal process are general in nature, offering few details about the MRP process. For example, information offered on the current WCB website gives only the following general information about the process:

*Medical Review Panel:*
An appeal on a medical issue can be brought to the Medical Review Panel after a decision by a WCB officer, the Review Board, or the Appeal Division. Requests for Medical Review Panel appeals must be made within 90 days following a decision made by one of these groups. The Medical Review Panel is the last method for appeals of a medical issue. For additional information on the appeals process, contact the nearest WCB office or toll-free at 1 800 661-2112. In the Lower Mainland, call 604 276-3067.

The current *Claims Appeal Guide for Workers and Dependents* offers the following information:

*Medical Review Panel:*
A Medical Review Panel consists of two appropriate Specialists (one chosen by you) and a Chair, who is also a doctor. This is the final level of appeal on medical issues; its decision is final and binding.

You can appeal a medical issue directly to a Medical Review Panel after a decision by a Board adjudicator, the Workers’ Compensation Review Board, or the Appeal Division of the Board. You have 90 days from the date of the letter containing the medical information you are challenging to appeal to a Medical Review Panel. There are no time extensions.

If you want advice on when to appeal to a Medical Review Panel, contact the Workers’ Advisers Office listed on page 2, or your union.

You need two forms to file an appeal:
- Request for Examination by a Medical Review Panel, or you can write a letter
- Certificate for appeal to a Medical Review Panel, which must be completed by a physician.

You can get these forms from: address, phone and fax] Fill out the forms and mail or fax back to: [address, phone and fax]
Toll free 1 800 661-2112. If there is a genuine medical dispute, the Medical Review Panel sends you a list of Specialists. You must select one from the list within eight days of receiving it.

You will be examined by the Medical Review Panel of two Specialists and one Chair. The Medical Review Panel decides the appeal. Its decisions on medical issues are final and binding.

Submissions and Reports

MRP Advisory Committee
In 1992 it was a "priority recommendation" of the MRP Advisory Committee that an information brochure about the MRP process should be created and made available to workers and employers:

The Committee concluded it would be helpful to issue a brochure describing the MRP process, particularly the examination process, for workers and employers. Such a brochure would not only be reassuring to workers having to undergo examinations, but would publicly document the standards which all MRP Chairmen would strive to maintain. One point that should be made in the brochure is that the Medical Review Panels are independent of the Workers' Compensation Board and unbiased in their consideration of the appeal. Before the next Committee meeting, each member will write out a list of matters to be covered by the brochure (from the point of view of the layperson).

Jenkins Report
Jenkins made a similar recommendation:

There should be guidelines for the Chairmen and Specialist Members as to the format of procedures involved in the conduct of an MRP. These guidelines should also be published in the form of a public brochure (perhaps with modification) so that the appellant may have a prior understanding of the examination process. The Registrar should develop this in consultation with the Chairmen and Specialist Members.

The Royal Commission has received a detailed draft information pamphlet describing the procedures and conduct of an MRP examination, which is not currently in use. This 15 page information package describes sites of MRP examinations; the conduct of MRP examinations; MRP reviews and fatalities; decisions of the MRP; the MRP medical certificate; the narrative report; implementation; and options for further information or inquiries. It also includes a 3 page description of the purpose and scope of the pamphlet.
Discussion

Current brochures and information packages published by the WCB describing the appeal process appear general in nature and offer few details. Submissions and reports agree that a detailed information brochure about the MRP process should available to workers and employers. A more thorough draft information pamphlet, such as the one described above, would promote understanding and enhance transparency.

Recommendations/Options

It could be recommended that a more detailed information brochure describing the MRP process, such as the draft described above, should be made available for workers and employers.
1. **EDUCATION, TRAINING, QUALIFICATIONS & PERFORMANCE ASSESSMENT OF CHAIRS AND SPECIALISTS**

1. **Education and Training of Chairs and Specialists**

**Summary of Issue**
A variety of education and training needs for MRP Chairs and Specialists have been identified since 1992. The purpose of the following discussion is to summarize these various submissions and recommendations.

**Law & Policy**

Education and training procedures for MRP Chairs and Specialists are not found in the Act or in published policy.

**Historical Debate**

**Jenkins Report**
Jenkins made the following recommendations concerning education, training, and qualifications of MRP Chairs:

- *Specific educational programs should be developed for new appointments and continuing appointments to include a curriculum of subjects that would be covered. This should be developed by the Registrar in consultation with the Chairmen. This process has begun.*

- *Current orientation for new Chairmen and Specialist members is not entirely adequate. This should be updated and expanded in an appropriate manner. The Registrar should be responsible for developing and coordinating this in consultation with the Chairmen.*

- *The WCB should continually improve continuing education and training for MRP Chairmen and Panel Specialist Members, making available to them information regarding relevant compensation issues, terminology, role, jurisdiction of MRP’s and any relevant issues. The Registrar should coordinate this.*

- *Educational and procedural sessions for Chairmen and relevant Specialist Members should be combined. Other interested parties should be invited, e.g. MRP Department members, legal counsel, Compensation Services personnel.*

- *There should be funding support to Chairmen, Specialist Members and MRP department staff for attendance at training/educational sessions. This should be a recognized budget item for the MRP Department.*
Medical Advisory Committee
In 1992 the MRP Advisory Committee commented that "a more organized orientation program is required for new Chairmen."

Gallagher Report
Gallagher made the following observations regarding the education and training of Chairs and Specialists:

Adjudicator training and orientation materials: physicians are not trained to be adjudicator’s and many of the requirements may be foreign to them, statutory jurisdiction, adjudicated independence, rules and national justice, pursue jewel fairness, to name only a few. And they cannot be expected to adequate understanding of their statutory role, and its limitations, unless it is explained to them. In the course of everyday business of the MRP department, there are clear examples of the panels not being adequately trained for their MRP roles.

Written orientation and training materials are at best rudimentary and they are not kept up-to-date. The “education days” that have been held are of real value; however, they have not covered all the important basics.

Gallagher asserted that "the quality of many certificates being issued by the MRP’s seriously detracts from the credibility of the MRP system" and that panel members often exceed their jurisdiction in preparing certificates. He determined that a "critical definition of the jurisdiction of MRPs" is needed as part of training for panel members:

There are physician-adjudicators whose turnaround times for certificates are consistently much longer then should be acceptable by any objective assessment, based on results delivered by their colleagues... Since the Act places total reliance on the certificate in the disposition of MRP applications, it is essential that the certificates be consistently of the highest quality. They are not. Certificates are often issued which are unclear, fail to answer specified questions or to answer them in sufficient detail. Some certificates include gratuitous comments or deal with extraneous matters which are irrelevant to the resolution of the bona fide medical dispute. This is a problem that may be corrected through education and training. There may also be situations where, if corrective measures are not effective, other forms of action maybe required, including termination of appointments. This is a matter of paramount importance because the issuance of certificates is the very purpose of the entire MRP system.

...Frequent difficulties with the certificates issued by panels reinforces this conclusion. Since the certificates issued by the panels are binding on the board, if a panel and exceeds its jurisdiction (example: considers questions that are not posed to them, or makes non-medical findings), or fails to exercise jurisdiction (example: fails to answer question posed them, or fails to have due regard for the
findings of non-medical facts within the file), the results can be serious for the parties of interest and may carry heavy cost implications for the accident fund.138.

He concluded that:

In consultation with the Chairs, Compensation Services and the Board’s legal staff, [should] develop a standardized format for certificates, including, with as much detail as possible, specifications for what is and is not to be included in certificates.

For the guidance of Chairs, examples of well prepared written certificates should be provided.139

Gallagher also concluded that "meets and bounds for the independence of MRP’s" should be explained to panel members:

There is no doubt that some of the physicians who serve as Chairs or Specialists on MRP panels do not understand the limits of their independence as adjudicators. Some seem to assume that they are empowered to do as they see fit in everything that touches on their performance of service for the MRP system. That is not the case in reality.

The Act empowers the physicians to perform specified tasks, grants them certain powers to enable them to perform those tasks and clothes them with a measure of independence. But their independence is limited. In other important respects they must take direction from the Act and remain in compliance with its terms. In providing their services they must be prepared to comply with reasonable directives and meet objective standards of performance. It is my view that some physician adjudicators cannot understand these limitations.

Furthermore, he determined that panel members need training respecting "role definition, objectives, goals controls, standards and monitoring of performance, effective communications and mechanisms for accountability":

It is very difficult to forge a team from highly individualist professionals who serve only on as-required basis, and to do not gather regularly for discussions about their work. However, that reality makes it doubly important to find other ways to ensure that the physicians who serve on MRP panels are working from common base of knowledge and striving to provide adjudicative services in a manner consistent with the requirements of the Act. It is important that they understand what the Act provides for in establishing the MRP system, and that they support defined objectives and goals of the department.

Gallagher concluded that Panel members should be provided with "appropriate hard copy materials" and "orientation training," which would contain explanations regarding:
a. Roles definitions, including a clear distinction between a physician’s role in the traditional practice of medicine and a physician-adjudicator in the workers’ compensation system.

b. A definition of an MRP’s jurisdiction.

c. Meets and bounds of the procedure role and substantive independence of an MRP, based on a written legal interpretation of the Act.

d. The MRP system’s objectives, goals, standards of performance and measurement, and quality assurance measures.

e. Standardized format for certificates.

He also recommended conducting "a workshop for Chairs to introduce a standardized format for certificates, and to provide instruction on how to write clear, concise certificates which satisfy the requirements of the Act and the Board." 140

1996 Annual Report

It was noted in the 1996 MRP annual report that some steps had been taken in response to the above criticisms:

The final area of positive action has been in the area of improved communication with the community based physicians used as Panel members and Chairs. This initiative encompasses quality control, education and process input. A series of regular meetings, usually quarterly, address Certificate clarity and scope as well as broader topics such as Compensation Services Division initiatives with the Chairs and their Advisory Committee. A real effort has been made by the Medical Review Panel Department to bring in knowledgeable teachers from other areas in order to enhance education. Panel Certificates, deemed problematic are reviewed in detail and direction is given.141

Medical Appeal Officers and MRP Administrative Staff

Medical Appeal Officers and MRP Administrative Staff had the following comments to make on this topic:

- In the past, Chairs and staff met all day for educational meetings.
- In more recent years, feedback has been given to Chairs once every six months or once per year, although the last time was 1 years ago.
- Chairs can inquire at any time respecting specific questions and they often do.
- There is no requirement for doctors to keep up with current medical knowledge after the cease practicing, as long as they pay their medical dues and are in good standing with the College. People complain about the fact that older doctors do not appear to have current medical knowledge, or about the fact that they are old in general and about their limited choices in terms of who is available to form an MRP panel.142
Current and Former MRP Registrars
At a recent meeting of current and former MRP registrars, the following summary of education programs was given:

- Printed materials are available for all Chairs.
- All materials are currently being gathering together for updating.
- An attempt is made to conduct an "education day" every six months.
- The last education day was in the fall of 1997.
- A speaker was brought during the fall of 1996.
- There is an acknowledgement that "it is time to get back to basics" regarding what constitutes a good certificate. 143

Discussion

Although there is evidence that some progress has been made in this area, indications are that there is room for more improvement. Sheardown has promised a report detailing the degree to which Jenkins’ and Gallagher's recommendations have been implemented. It would be premature to make final recommendations in this area. This could be done once that report has been received and reviewed.

Options

Depending on Sheardown's report, some or all of the suggestions outlined above could be recommended in order to improve education and training of panel members.

2. Quality assurance and performance assessments of Chairs and Specialists 144

Summary of Issue
The need for quality assurance and performance assessments respecting MRP Chairs and Specialists has been an issue for a number of years. The purpose of the following discussion is to summarize these submissions and recommendations.

Law & Policy

Quality assurance and performance assessment procedures for MRP Chairs and Specialists are not found in the Act or published policy.

Submissions and Reports

Jenkins Report
Jenkins made the following recommendations respecting quality assurance and performance assessment of Panel members:
Activities such as conduct of Panels, drafting of Certificates and Narratives should be monitored for quality on as objective a basis as possible, built upon criteria developed by the Registrar, in consultation with the Chairmen. The intent and objectives are for facilitation and improvement, not legislation.\textsuperscript{145}

There should be a quality monitoring process for performance of Chairman and Specialist Members.

It should take the form of a set of standards expected of the Chairman and Specialist Members in the performance of their duties and functions on an MRP. The standards should be set to buy and advisory committee of Chairman and Specialist Members and reported to the Registrar, who would coordinate this activity.

The monitoring would be done by an advisory committee on quality assurance, composed of three Chairman elected by their Chair colleagues. The Registrar would act as Coordinator and Chairman of the committee. The Quality Assurance Committee would also monitor the Specialist Members’ performance. The committee would meet on a regular basis.

Training/educational guidelines should be developed for Chairman and Specialist Members. These should be coordinated by the Registrar, in consultation with the Chairman and Specialist Members.\textsuperscript{146}

Gallagher Report

Gallagher made the following observations about accountability and quality assurance for panel members:

[Panel members] must subscribe to and to satisfy certain standards of performance, work within prescribed controls, and be held accountable when their conduct or performance is at odds with these. Dr. Jenkins and others who serve on the Chairman’s Advisory Committee, have worked to bring about these results, but they must be provided with management direction and assistance.\textsuperscript{147}

Gallagher also recommended instituting a quality assurance program:

As an integral part of an ongoing quality assurance program, provide each Chair with objective comparative data that will allow them to assess and compare their own performance to that of all the Chairs, taking care to preserve confidentiality for all Chairs.\textsuperscript{148}

Discussion

As discussed, Sheardown has promised a report detailing the degree to which Jenkins’ and Gallagher’s recommendations have been implemented. Until such time, it would
be premature to make final recommendations in this area. This could be done once that report has been received and reviewed.

**Options**

Depending on Sheardown's report, some or all of the suggestions outlined above could be recommended in order to improve quality assurance and performance assessments of panel members.
J. **Training, Qualifications & Performance Appraisals of MAOs and MRP Department Administrative Staff**

**Summary of Issue**
A variety of the education and training needs for MAOs and MRP Department administrative staff have been identified since 1992. The following discussion summarizes these submissions and recommendations.

**Law & Policy**

Education and training procedures for MAOs and MRP Department administrative staff are not found in the Act or in published policy.

**Historical Debate**

**Jenkins Report**
Jenkins made several recommendations respecting the education and training of MRP Department members, including MAOs:

- *The training program for new MAOs should be more formalized. A training manual should be developed by the manager and MAO current staff. Funding and opportunities should be made available for new and updating courses. The Registrar and Manager of the Medical Review Panels should oversee this activity.*

- *There should be funding support to ... MRP department staff for attendance at training/educational sessions. This should be a recognized budget item for the MRP Department.*

- *[MRP Department staff should be invited to attend educational and procedural sessions for Chairs and Specialists].*

Jenkins made the following recommendations respecting quality assurance and performance monitoring of MRP administrative staff:

*A quality assurance program should be in place for the MRP Department. The MRP Manager and Registrar should oversee this.*

**Gallagher Report**
Gallagher made the following observations regarding training, qualifications and performance assessments of MAOs and MRP Department administrative staff:

*The administrative procedures involved in handling MRP cases have not been committed to writing for the guidance of the administrative staff.*

*Staff training/retraining is addressed only on and as-required basis; there are no hard-copy training modules for the orientation of new employees in any of the*
job positions within the MRP department. As changes in staff occur, it falls to the senior MAO to leave the performance of key duties to conduct ad hoc orientation and training.

There are no hard copy materials relating to performance and productivity standards or expectations, or methods of assessing results.

Gallagher made the following recommendations on this topic:

- Provide training for the Registrar, Assistant Registrar and Senior MAO, so that they are capable and confident in designating appropriate Specialists for MRP examinations.
- In consultation with administrative and adjudicative staff members, identify general and specific needs for performance related education and training.
- Within specified guidelines, provide administrative staff members with access to external education and training opportunities that are linked directly to more effective an efficient performance of assigned duties in the service of the MRP system.
- Develop and maintain hard-copy training modules for the orientation and training of newly appointed employees, on a position and function specific basis.

Current debate

MRP Department 1998 Business Plan
It is stated in the MRP Department 1998 Business Plan that, as a "critical success factor," the MRP Department "must be staffed adequately with trained and committed administration and adjudicative personnel."

Medical Appeal Officers and MRP Administrative Staff
Medical Appeal Officers and MRP Administrative Staff recently had the following comments to make regarding staff training:

- Staff training is still carried out on an ad hoc basis, primarily through a mentoring process for approximately one-year.
- There are also education days and computer training.
- The MAO Manual is still out of date. The department is in the process of trying to put together a new up-to-date manual.

Current and Former MRP Registrars
Current and former MRP registrars recently made the following comments about current training methods for Medical Appeal Officers:

- There is no formal training program.
- Training is done through a mentoring process.
- This is done by a senior MAO.
- "We acknowledge that training is inadequate."
- There is also a two-day course.
- Maybe qualifications should be raised respecting analytical ability and judgment, given that they will be subject to the scrutiny of lawyers and appeal panels.
- MAOs who have been around longer do much better and are much faster. There is a huge difference in productivity.
- More education is needed around evidence and decision-making, although this is almost a non-teachable skill which requires experience.

**Discussion**

It would be premature to make final recommendations in this area until Sheardown's report has been received. However, it is clear from recent discussions with MRP administrative staff, MAO's and current and former MRP registrars that training is currently inadequate.

**Options and Recommendations**

Depending on Sheardown's report, some or all of the following recommendations could be made in order to improve training of MAO's and MRP administrative staff:

**Training and Education**

- A committee comprised out individuals or groups with relevant expertise could be constituted to determine an appropriate training program MAO's and MRP administrative staff.
- The training program could be made more formalized.
- Both internal and external education and training opportunities could be provided.
- Training could be provided for the Registrar and Assistant Registrar.
- Training manuals could be brought up to date and could include hard-copy training modules.
- Additional funding could be directed towards training and educational sessions.
- MRP Department staff could be invited regularly to attend educational and procedural sessions for Chairs and Specialists.

**Quality Assurance/ Performance**

- A quality assurance process could be put in place for MAO's and MRP administrative staff
K. **Timeliness: Eliminating Time Delays Associated with MRP Reviews**

**Summary of Issue**

Workers, employers, MRP physicians, MRP staff and WCB management have voiced their concern that delays in the processing of MRP applications are lengthy and unacceptable and that backlogs should be eliminated.

On the other hand, the Medical Advisory Committee has recently expressed some optimism regarding the resolution of this problem:

> With the current trend of statistics on performance of the Medical Review Panels as of September 1997, the department is on track to meet the goal of significantly reducing the backlog and bringing the process into the current year of application. Much progress has been made within the past one year. Optimistic forecasting is justified.\(^{155}\)

It is clear that delays in the MRP system have been an ongoing problem. For example, in 1994 average processing time was 742 days or 24.73 months. In 1995, the average processing time from initiation to completion of the MRP process was slightly longer -- 707 days or 23.57 months It was acknowledged in the 1995 MRP annual report that, despite this slight improvement, “delays within the MRP process continue to be a critical challenge for the department.”\(^{156}\)

In the Royal Commission cohort study the average number of days from application date to certificate was 614 days.

A variety of contributing factors have been identified since 1992 by Jenkins, Gallagher, Brake, the Medical Advisory Committee, the MRP Department (including current and former MRP Registrars and MRP Staff), workers and employers and stakeholder counsel, including the following:

- increased intake and inadequate staffing;
- inefficiencies at each stage of the process;
- ambiguities and voids in legislation;
- misuse of the Narrative;
- overuse of the statement of foundational non-medical facts;
- use of an outdated computer system;
- inadequate education, training and qualification processes;
- inadequate direction and control of Chairs and Specialists
- inadequate management and quality assurance mechanisms; and
- unavailability of Specialists.\(^{157}\)

The first three factors in this list are discussed below. The remaining factors have been addressed as separate topics in this Report.
1. Inadequate Staffing
   
a. Inadequate Intake Staffing

Summary of Sub-Issue

In 1992 the MRP Advisory Committee predicted that the intake would increase and the backlog would continue to grow:

The Registrar hopes that it will be possible for Medical Review Panels to issue 300 certificates in 1993 (an increase of approximately 100 over 1992) With an influx of 500 new applications yearly, however, the backlog will continue to grow.\(^{158}\)

This prediction has proved to be correct. Intake has increased and has contributed to delays and backlogs. For example, the following trends were noted in the 1996 MRP annual report:

Activity in the Department reached its highest level in the history of the process. 607 new applications were received - an increase of 17% over 1995. The source of the majority of these applications continues to be Appeal Division decisions (56%), although other sources are decisions of Board Officers (27%) and Review Board findings (14%). Worker requests for Panel examinations also continue to be the bulk of these new applications - 92% in 1996.

Fluctuations in intake levels since 1987 are shown below:\(^{159}\)
While intake increased in 1996, fewer Panels were held and there was a decrease in decisions issued:

A total of 198 Medical Review Panels were held during the year - a significant decrease from 1995...\textsuperscript{160} There were 211 Panel certificates issued in 1996, a 57% decrease over 1995.\textsuperscript{161}

It was noted in the 1996 MRP annual report that “in 1995, new delays at the Bona Fide Medical Dispute Decision and File Review stages were created and this trend continued through 1996.”\textsuperscript{162}

**Submissions and Reports**

**Brake Report**

In 1994, former MRP registrar Weldon Brake recommended several initiatives designed to alleviate the backlog problem, including the creation of 2 new Intake Clerk positions.\textsuperscript{163}

**MRP Annual Report**

It was noted in the 1996 MRP annual report that the addition of new staff has helped to solve the intake problem to some degree:

The Intake, or front end of the Department was also strengthened with the addition of an Intake Clerk. This position was carefully considered as the individual can fulfill a multi-task support role. The Medical Review Panel Department is now in a staffing position to complete the task of making inroads toward shorter processing times and backlog eradication.\textsuperscript{164}

**Discussion**

The MRP response in this area appears reasonable. Increased staffing is a logical response to intake increases which contribute to delays.

**Options/ Recommendations**

It could be recommended that close monitoring of intake trends be continued to insure that intake staffing is adequate.

**b. Inadequate MAO Staffing**

**Summary of Sub-Issue**

In May 1995 a decision was made to reduce the number of Medical Appeals Officers from 7 to 2. As noted in the 1996 "Medical Review Panel Report" the impact of this decision was felt in 1996.
In 1996, Gallagher strongly objected to the reduction in the number of MAO's as unreasonable and illogical. In 1996 Gallagher described in much detail all of the functions carried out on regular basis by the MAO. It is evident from this description that the tasks of MAOs are complex and numerous, and that the discontinuation of the Statement was inadequate justification for reducing the numbers from 7 to 2.

As a result, "a study was commissioned in February 1996 and a report was tabled in August 1996. An initiative was subsequently begun to increase the Medical Appeals Officer staffing levels from 2 to 5 officers. This was completed by November 1996."

**Submissions and Reports**

**Current and Former MRP Registrars**

MRP Registrar Sheardown agreed that a number of good MAOs were lost in the 1995 downsizing. She commented that, when there were only 2 MAOs there was no longer a production engine and expressed the hope that some may be enticed back eventually.

**Medical Review Panel Advisory Committee**

Dr. Ian Connell, MRP Chair and Medical Review Panel Advisory Committee Member, recently agreed that cutting the number of MAOs from 7 to 2 contributed to delay problems, given the expectation of approximately 700 files per year.

In its submission to be Royal Commission the Medical Advisory Committee made the following comments on the topic:

> Despite the recommendations of the Jenkins report, the number of Medical Appeals Officers was drastically reduced in 1995 and a substantial backlog of claims resulted. Administrative changes have since been made and staffing, especially the Medical Appeals Officer component, is now at an appropriate level and support staff have been made more relevant.

**MRP Department 1998 Business Plan**

It is stated in the MRP Department 1998 Business Plan that, as a "critical success factor," the MRP Department "must be staffed adequately with trained and committed administration and adjudicative personnel." It was also noted that "the officer level positions which drive production will remain staffed in 1997 levels insuring future production capacity."

**Discussion**

It appears MAO staffing is now at an appropriate level.

**Options/ Recommendations**

It could be recommended that MAO staffing be maintained at its current level.
2. **Eliminating Inefficiencies at Each Stage of the Process**

**Summary of Sub-Issue**

Since 1992, a variety of streamlining efforts have been recommended and/or attempted during different stages of the MRP process to reduce or eliminate inefficiencies.

The following graph from the 1995 MRP annual report illustrates the various stages and compares MRP processing times from 1991 to 1995:

![Graph showing processing time comparison from 1991 to 1995.]

Note that the above graph generalizes the stages to some degree. In fact, the following additional stages fall between the BFMD decision and the scheduling of the Panel:

- Specialty designated;
- File reviewed by MAO;
- Statement of Issues prepared;
- Medical information requested;
- Doctors precluded;
- Parties asked to nominate Specialists;
- List of material to be sent to Panel prepared;
- Doctors reply about nomination and availability Medical information gathered and reviewed.\(^{171}\)
As well, the following additional stages fall between the scheduling of the Panel and the holding of the Panel:

- Panel composition, date and venue set;
- Final arrangements with worker and Panel members made; [and]
- File prepared and sent to Panel.\textsuperscript{172}

The Royal Commission’s cohort study indicates that the average and median number of days between stages was as follows:

<table>
<thead>
<tr>
<th>Stage</th>
<th>Avg.</th>
<th>Med.</th>
</tr>
</thead>
<tbody>
<tr>
<td>MRP Application</td>
<td>62</td>
<td>65</td>
</tr>
<tr>
<td>BFMD Cert. Rec’d</td>
<td>61</td>
<td>0</td>
</tr>
<tr>
<td>Decision date</td>
<td>166</td>
<td>178</td>
</tr>
<tr>
<td>Certificate date</td>
<td>325</td>
<td>288</td>
</tr>
</tbody>
</table>

This shows that the average number of days from MRP application was 614 days. The median was 531 days. The longest waiting period occurred between the BFMD decision and the MRP certificate date.

**Submissions and Reports**

**Jenkins Report**

In 1992, Jenkins described the reduction or elimination of the causes of delays in the MRP system as an "imperative" matter "in order to maintain the system as a success and not lose its credibility."\textsuperscript{173} He focused on several stages in the MRP process and made the following recommendations regarding time limits:

- Although the time factors for initiating a Medical Review Panel Appeal are relevant, they can, on occasion, be too restrictive. There are extenuating circumstances in which the 90 day time limit under section 58(3) should be waived. The opportunity to establish an appeal in the MRP process should not be lost on a technicality beyond the appellant’s control.

- Guidelines should be developed for extenuating circumstances. The authority for extending time limits should be assigned to the Medical Appeals Officer...\textsuperscript{174}

- There should be suggested time limits, as a guideline only, for Panels issuing Certificates. A six-week time limit would seem reasonable.\textsuperscript{175}

- The reasons for delays in MRP certification implementation should be identified and measures taken to minimize the factors leading to delays.

- Dispute resolution processes should be managed as efficiently and quickly as possible in order to reduce lengthy and costly delays in the implementation of the MRP Certificate.\textsuperscript{176}
Brake Report
In 1994, former MRP registrar Weldon Brake commented that the following procedural initiatives were "being pursued and implemented" to speed up the process:

- having specialties designated by the Registrar at the beginning of the process;
- initiating employer/worker nominations for Specialists at the beginning of the process;
- scheduling of the panel examination date as soon as the nominations have been completed;
- introducing a more integrated scheduling approach.

1996 MRP Annual Report
In the 1996 Medical Review Panel Report it was noted that "the challenge of the Medical Review Panel Department is to focus all efforts on streamlining the processing of requests for panel examinations to reduce delays." As well, a detailed breakdown was presented, illustrating target processing times for the various stages of the MRP process:

The Medical Review Panel Department is now in a staffing position to complete the task of making inroads toward shorter processing times and backlog eradication. The goal of 120 days processing time can now be realistically worked towards.

To conclude, it is important to explain that, with the addition of staff, came the identification of a processing time goal of 120 days. This is the average number of days processing time from when an appeal is initiated to when it is sent to a panel of physicians. The goal is broken down as follows, giving each area time targets:

Step 1: 15 days
- Application complete
- BFMD decision
- Specialty designated

Step 2: 30 days
- File reviewed by MAO
- Statement of Issues prepared
- Medical information requested
- Doctors precluded
- Parties asked to nominate Specialists
- List of material to be sent to Panel prepared
Step 3: 30 days

- Doctors reply about nomination and availability Medical information gathered and reviewed

Step 4: 15 days

- Panel composition, date and venue set

Step 5: 30 days

- Final arrangements with worker and Panel members made
- File prepared and sent to Panel

The Department feels the AND goal will be achieved by the second or third quarter, 1998.

MRP Department 1998 Business Plan

It is noted in the 1998 MRP department Business Plan that "the future activities of the Medical Review Panel continue to be aimed at reducing the average number of days an appeal takes from opening to closure."

One goal is to "reduce the number of cases awaiting processing at the Medical Appeals Officer level by 50%.

The strategy proposed in order to accomplish this objective is to "[d]evelop a work plan with the Medical Appeals Officers to identify priority cases and schedule for implementation." The corresponding action plan includes the following:

- identification of the number of cases awaiting processing;
- determination of the priority of cases;
- assessment of the capacity of staff to process bona fide medical dispute decisions and file review stages;
- setting of monthly targets; and
- monitoring and assessing of progress.

Another goal is to "[r]educe the Average Number of Days (ANDs) required to receive, process and decide MRP matters by 50% in 1998."

The strategy proposed for accomplishing this goal is to "evaluate and adapt where necessary the new process redesign adding software where feasible." The corresponding action plan is as follows:

- development of a job description and hiring of the new manager for the MRP department;
- examination and cleanup of the AND statistics in order to eliminate periods of time for which the MRP department is not accountable;
- consideration of a detailed cost investigation for replacement of the Appeals Management System (AMS); and
- procurement of a "scheduling tool (software) for the scheduling clerk."\textsuperscript{185}

It was concluded in the Business Plan that "the platform for continued production which will bring the department closer to its goal of 180 days turnaround has been built."\textsuperscript{186}

**MRP Registrar**

MRP Registrar Sheardown recently stated that most delays are internal and that front-end productivity is the main problem. She noted that there is always a time lag respecting panel scheduling because physicians need a lot of lead time to arrange their schedules. However, she stated that most complete the certificates quickly.

She made the following comments regarding the feasibility of achieving a target of 4 to 6 months:

\textit{I think that that [the target of 4 to 6 months] is achievable but [not] by someone who is putting their appeal in today ... because we are now assigning files that were received in August. If we continue to reduce that backlog and based on current application levels and production levels from last year, which we hope to improve that backlog should be eliminated by the end of this year. They certainly still would have the waiting period on the front end until it comes under the consideration of the medical appeal officer. I have no way of knowing what at what point the backlog will be eliminated but my prediction based on things that can change is November of this year. Our target would be 4 to 6 months. In December of 1997 the median elapsed time as opposed to the average or was 17.5 months from complete application to closure. If we can eliminate that backlog by 7 months then we are down to 10. Hopefully the production targets we hit in the education that we can do with the medical appeals officers and the systemic review can reduce that further.}\textsuperscript{187}

**Medical Review Panel Advisory Committee**

Dr. Ian Connell, MRP Chair and Medical Review Panel Advisory Committee Member, recently commented that, in his opinion, it should take a maximum of the six months from the receipt of the enabling certificate to the Panel's certificate. Dr. Jenkins stated that the Chairs believe there should be a six-week maximum from the panel examination to the finding of the Panel (barring having to wait for further information).\textsuperscript{188}

**Stakeholder Counsel - Steeves**

J. Steeves commented that "the primary concern of workers with respect to the medical review panel is the delay."\textsuperscript{189} He made the following submission on behalf of the BC Federation of Labour:

\textit{The Board explained that the current backlog in the Board's Medical Review Panel Department means that it takes about 7 months for a workers' appeal to get before a}
Normally the panel's Certificate is issued very soon after the examination of the worker. Therefore, the delay is within the Board and not with the panels themselves.

The Board explained that they thought 4 months was an appropriate time from the time the threshold issues of whether there is a bona fide medical dispute and whether there are sufficient particulars to the time the worker is examined by a panel. We believe the time should be 90 days and we recognize that there is some time required for determination of the threshold issues...

We recommend that section 58 of the Act be amended to require the examination of a worker by a Medical Review Panel within 120 days of receipt of a Certificate of a Bona Fide Medical Dispute. ¹⁹⁰

**Stakeholder Counsel - Sayre**

Sayre concurred with Steeves that delays are of concern to workers "perhaps… more than anything else". ¹⁹¹

**Discussion**

The following graph illustrates the various MRP targets and stakeholder proposals:

## TARGETS AND PROPOSALS

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<td>Application date</td>
<td>15 Days</td>
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<td>30 days</td>
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<td>Certificate Received</td>
<td>30 days</td>
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<td>BFDM Decision</td>
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<td>Specialty</td>
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<td>Material Designated</td>
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<td>Medical List Sent</td>
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<td>Panel Composition</td>
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<td>File Prepared</td>
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<tr>
<td>Hearing</td>
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<td>MRP Date, Venue</td>
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<td>Implementation</td>
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</table>
All of these targets and proposals envision time frames which would be much shorter has occurred in the past. For example, the 1998 MRP Business Plan describes a target of 180 days from application date to MRP certificate. For the same time frame, the cohort study shows that the average number of days from MRP application was 614 days and the median was 531 days. The 1995 and 1996 MRP annual reports indicate that the AND was approximately 700 days during this time frame. Sheardown has stated that the median elapsed time "from completed application to closure" for 1997 was 17.5 months or 525 days.

While it may be difficult to assess precisely how long each stage should ideally take to complete, it is clear that MRP stated goals have not been met in the past and that this continues to be a serious problem.

One option for addressing this problem would be to make all or some of the targets proposed by the MRP department mandatory under the Act. However, this would probably be premature, given the existing backlog and the projections of Sheardown.

The steps proposed in the 1998 MRP Department Business Plan, to "reduce the number of cases awaiting processing" at the MAO level and "reduce the average number of days required to receive, process and decide MRP matters" may have some positive effect. It would also be reasonable for the MRP Department to focus on developing solutions for delays in stages which are most problematic. For example, according to the cohort study, the longest waiting period occurred between the BFMD decision and the MRP certificate date. It could therefore be recommended that the stages within this time frame be examined more closely to determine whether additional measures could be taken.

Sheardown has indicated that there is always a time lag respecting panel scheduling because physicians need a lot of lead time to arrange their schedules. Recommendations discussed elsewhere in this report may help alleviate this problem, including:

- Part C (respecting the number and availability of Chairs and Specialists); and
- Part I (respecting education, training, qualifications and performance assessments of Chairs and specialist).

Sheardown has also indicated that most delays are internal and that front-end productivity is the main problem. Recommendations discussed elsewhere in this report should help in this regard as well, including:

- Part H (concerning the need to update the MRP Department computer system);
- Part K.1 (inadequate intake staffing); and
- Part J (Improved training, qualification and performance appraisals for MAOs and MRP administrative staff).
**Options/ Recommendations**

It could be recommended that all or some of the targets proposed by the MRP department should be made mandatory under the *Act*, once the backlog has been eliminated and it can be demonstrated that such goals can be achieved.

It could be recommended that the MRP Department should focus on developing solutions for delays in stages of the MRP process which are most problematic. For example, the steps between the BFMD decision and the MRP certificate could be examined more closely.

Recommendations discussed elsewhere in this report may help alleviate the time lag respecting panel scheduling due to physicians need for lead time to arrange schedules, including:

- Part C (respecting the number and availability of Chairs and Specialists); and
- Part I (respecting education, training, qualifications and performance assessments of Chairs and specialist).

Recommendations discussed elsewhere in this report should address the fact that most delays are internal and that front-end productivity is a significant problem, including:

- Part H (concerning the need to update the MRP Department computer system);
- Part K.1 (inadequate intake staffing); and
- Part J (Improved training, qualification and performance appraisals for MAOs and MRP administrative staff).

3. **Eliminating Ambiguities and Voids in Legislation**

**Summary of Sub-issue**

Ambiguities and voids in sections 58-66 of the *Act* may contribute to delays.

**Law and Policy**

The Act contains a number of non-specific time limits for completing the MRP process. WCB policies provide further guidance in the interpretation of these provisions:

- Under s.58(5) of the Act, "the Board may decide that the worker shall be examined by a Medical Review Panel, in which case he shall be so examined in the manner provided by this section." Under s.103.30 of the RSCM, **no time limit** for such a referral is applicable. This section may be used by the WCB in "some situations to ensure that procedural difficulties related to the
commencement of a MRP (e.g. missing the 90 day time limit) do not preclude access to the MRP process for purely technical reasons.\textsuperscript{193}

- Under s.59(1) of the Act, the WCB must, \textbf{within a reasonable amount of time}, be sent a notice by registered mail to the worker and the employer requiring each to nominate a Specialist from the list provided by the WCB under s.58(2) of the Act, within 8 days of receipt of the notice.

- Under s.60 of the Act, the Chair of the MRP is required to arrange for examination of the worker \textbf{within a reasonable time} after the appointment of the Specialists.\textsuperscript{194}

- Under s.63 (2), on receipt of an expression in writing that a dependant of a deceased worker is aggrieved by a finding of the WCRB or a decision of the WCB concerning the cause of death, the WCB must, \textbf{within a reasonable period of time}, require the dependant and the last employer of the worker to, nominate a Specialist within 8 days.

- Under 63(4), \textbf{within a reasonable time after the inquiry} the Chair must send a certificate to the board setting forth the cause of death ascertained by the panel.

- Section.61(7) of the Act, which provides that: "[within 18 days or the further time that the board considers necessary] of the receipt of the certificate from the Chairman of the medical review panel, the board shall review the claim and send a true and complete copy of the certificate to the worker, to the physician whose certificate accompanied the request under s.58(3) or (4) and to the employer."

- If, \textbf{within a reasonable period after a certificate is issued}, perhaps one year, new evidence becomes available indicating a fundamental mistake has been made and if it is possible for the Board to reconvene the MRP which issued the certificate the Board may at its discretion do so.\textsuperscript{195}

\textbf{Submissions and Reports}

In 1996, Gallagher expressed concern about ambiguities and voids the \textit{Act}. His comments were as follows:

\textit{When examining the MRP department and its workings with a view to the identification of factors contributing to time delays, it quickly becomes apparent that many of the problems being experienced within the MRP system relate back to ambiguities and voids in Sections 58-66 of the Act. The lack of clarity and precision contributes to imprecision in the systems and processes employed within the MRP system.}

\textit{When considering time delays being experienced within the MRP system, some can be traced back directly to either a lack of precision in the direction provided by the Act, or to a total lack of direction. Examples: [Sections 59(1), 60, 61(1), 63(2) and 62(4) and 61(7) are quoted by way of example]}
The Act does not provide time limits within which an MRP must provide its certificate after conducting an examination, nor for the implementation of certificates after they have been delivered to the Compensation Services Division of the Board by the MRP department.

The absence of specific time limits in the Act has been the source of time delays at other times in the Board’s history. Where specific time limits have been added by statutory amendment, as in the case of the Appeal Division, marked improvements in disposing of cases in a timely manner have been realized.\(^\text{396}\)

**Medical Review Panel Advisory Committee**

Dr. Ian Connell, MRP Chair and Medical Review Panel Advisory Committee Member, recently suggested that legislation should contain broad, overall time limits for the process, as opposed to many time limits for each component of the process.\(^\text{197}\)

**Discussion**

The statutory provisions described above add an element of uncertainty and may contribute to delays. However, as discussed, it is difficult to determine with precision optimum time periods for the various stages of the MRP process. The lack of consensus in this area is evidenced in the graph in Part K.2 of this chapter (entitled “targets and proposals”).

As well, it is unclear what the MRP response has been (if any) to this recommendation of Gallagher. As noted above, it is expected that this question will be answered in a report to be provided by Sheardown.

These uncertainties should not necessarily preclude statutory amendment. It could be recommended that the MRP Department determine appropriate time limits for the above provisions, based on its experience. Such time limits could eventually be made mandatory under the Act, once it can be demonstrated that they are achievable.

**Options /Recommendations**

It could be recommended that:

- the MRP Department should determine appropriate time limits for the above provisions, based on its experience; and
- such time limits should be made mandatory under the Act if can be demonstrated that they are achievable.
ENDNOTES

1. RSCM, p.12-32.

2. thereafter (Forms 11c - 11n). Form 11A is the Physicians Report Account". [RSCM, p.12-15, 12-16].

3. Act, s.56. Attending physicians and other qualified medical practitioners who attend or consult on a case involving (alleged) injury to a worker in an industry within the scope of Part I of the Act must, within three days of first attendance upon the worker, file a Form 8. (Form 11) or comparable forms for other practitioners, must be sent regularly.

4. RSCM, p.12-32.

5. Panel certificates are binding under s.65 of the Act. Judicial review may be available under limited circumstances.


7. RSCM #103.20.

8. As of Sept. 18th, 1997 there were 13, 5 or 6 full-time - interview with MRP Dept. Registrar, Sept.18, 1997.


10. RSCM 13-23.


12. [RSCM, p.13-23] Under s.59(3), the WCB must appoint the Specialists nominated as members of the MRP (provided the Specialists accept) within 18 days of the receipt of the nominations. If the Specialist does not accept, or if he or she is unable to participate, another Specialist must be nominated. [s.59(4)]. Under s.59(3), The WCB will appoint the chair of the MRP. [RSCM, p.13-24, Act, s.59(5)].

13. Under s.58(3), a worker is entitled to be examined by an MRP where the worker is aggrieved by a medical decision of "the board" (a WCB adjudicator or the Appeal Division), or by a medical decision of the WCRB, and there is a bona fide medical dispute to be resolved. The worker has 90 days from the finding or decision to appeal the decision. The worker may do so by writing to the WCB and sending a sufficiently detailed certificate from a physician certifying that there is a bona fide medical dispute to be resolved.

14. Under s.58(4), an employer is entitled to have a worker examined by an MRP where the employer is aggrieved by a medical decision of "the board" (a WCB adjudicator or the Appeal Division), or by a medical decision of the WCRB, and there is a bona fide medical dispute to be resolved. The employer has 90 days from the finding or decision to appeal the decision. The employer may do so by writing to the WCB and sending a sufficiently detailed certificate from a physician certifying that there is a bona fide medical dispute to be resolved. A Medical Appeals Officer or the Assistant Registrar will decide whether a valid physician's certificate has been provided in support of the appeal [RSCM, p.13-17 to 13-21].

15. Decision of the Governors, #75 ("published policy").


19. MRP meeting at Commission office, afternoon session, April l 28th, 1998,
In attendance: Judge Gill; Patrick Lewis; Gerry Stoney; Sharon Samuels; Leigh Sheardown, Current Registrar; Dave Martin, Past Registrar; Jan Dicks, Manager. Not necessarily a verbatim quote. Excerpted from notes taken by S. Samuels.

MRP meeting at Commission office, afternoon session, April 128th, 1998.


Judicial review may be available under limited circumstances.

MRP meeting at Commission office, afternoon session, April 128th, 1998.

"Royal Commission on Workers' Compensation in BC," 2nd Phase Hearings, 1998 at p.70.

J. Sayer, "Royal Commission on Workers' Compensation: Presentation on Behalf of Injured Workers" 1998 at p.50.

This suggestion was also made by the Ombudsman in 1987, who stated that "applications for referral of medical disputes to the MRP [should] be decided by the WCRB." [Ombudsman of BC, Workers’ Compensation System Study, Report No.7, July 1987, recommendation #30].


"Royal Commission on Workers' Compensation in BC Submission Summary," 2nd Phase Hearings, Stakeholder Counsel, Notetaker: Steven Noble, April 15 AM, 1998, at p.34.


J. Sayer, "Royal Commission on Workers’ Compensation: Presentation on Behalf of Injured Workers" 1998 at p.49.

"Royal Commission on Workers' Compensation in BC Submission Summary," 2nd Phase Hearings, Stakeholder Counsel, Notetaker: Steven Noble, April 15 PM, 1998, at p.23.

"Royal Commission on Workers’ Compensation in BC Submission Summary," 2nd Phase Hearings, Stakeholder Counsel, Notetaker: Steven Noble, April 15 AM, 1998, at p.28.

MRP meeting at Commission office, afternoon session, April 128th, 1998.

In attendance: Judge Gill; Patrick Lewis; Gerry Stoney; Sharon Samuels; Leigh Sheardown, Current Registrar; Dave Martin, Past Registrar; Jan Dicks, Manager.

June 13, 1997 - Meeting at Royal Commission - Notes of SJS.


"Submission to the Royal Commission on the Workers’ Compensation Board from the Chairs of the Medical Review Panels ", received October, 1997.

As of Sept. 18", 1997 the were 13, 5 or 6 full-time - interview with MRP Dept. Registrar, Sept.18, 1997.

RSCM p.13-23.

RSCM 13-23.

"Jenkins Report" at p.63.

"Jenkins Report" at p.62.

"Jenkins Report" at p.62.
Minutes of the MRP Advisory Committee, Dec. 21, 1992, at pp.4-5.
Present: Dr, Nigel H Clark, Dr, Ian Connell, Dr. J. T. Sandy (MRP Chairs and Members of the Advisory Committee); Dr, Leonard C. Jenkins, MRP Registrar; Heather Green, Legal Advisor, Office of the Board of Governors

“The Committee accepted the recommendation that the composition of the joint medical committee should be expanded. The existing three positions should be retained. (The joint medical committee is currently composed of the Registrar College of Physicians and Surgeons of B.C., the Executive Director of the BCMA, and the Assistant Executive Director of the BCMA, all of whom belong to the committee by virtue of their positions.) Three new positions added - a member at large from the College, a member at large from the BCMA and the Dean (or designate) of the USC Faculty of Medicine.”

Minutes of the MRP Advisory Committee, Dec. 21, 1992, at p.6.

This is part of the recommendation that the MRP process should be integrated with a single, independent appeal Submission by the Worker’s Compensation Review Board to the Royal Commission on Workers’ Compensation, Jan 31, 1998.

"Jenkins Report" at p.63.
"Jenkins Report" at p.63.
"Jenkins Report" at p.63.
"Jenkins Report" at p.61.
"Jenkins Report" at p.63.
"Jenkins Report" at p.62.
"Jenkins Report" at p.61.

Minutes of the MRP Advisory Committee, Dec. 21, 1992, at pp.5-6.
Present: Dr, Nigel H Clark, Dr, Ian Connell, Dr. J. T. Sandy (MRP Chairs and Members of the Advisory Committee); Dr, Leonard C. Jenkins, MRP Registrar; Heather Green, Legal Advisor, Office of the Board of Governors.

Minutes of the MRP Advisory Committee, Dec. 21, 1992, at pp.4-5.
Present: Dr, Nigel H Clark, Dr, Ian Connell, Dr. J. T. Sandy (MRP Chairs and Members of the Advisory Committee); Dr, Leonard C. Jenkins, MRP Registrar; Heather Green, Legal Advisor, Office of the Board of Governors.

Minutes of the MRP Advisory Committee, Dec. 21, 1992, at pp.4-5.
Present: Dr, Nigel H Clark, Dr, Ian Connell, Dr. J. T. Sandy (MRP Chairs and Members of the Advisory Committee); Dr, Leonard C. Jenkins, MRP Registrar; Heather Green, Legal Advisor, Office of the Board of Governors.

Gallagher Report, p.60.

She noted that the BCMA is reluctant to appoint because of a concerned that it may be a conflict for them, since it is their role to act for all Specialists. They also have concerns about Freedom of Information. If records were to be released indicating that the College had determined that one Specialist was good enough to be recommended while another was not, this could cause problems.

MRP meeting at Commission office, afternoon session, April 1 28th, 1998,
In attendance: Judge Gill; Patrick Lewis; Gerry Stoney; Sharon Samuels; Leigh Sheardown, Current Registrar; Dave Martin, Past Registrar; Jan Dicks, Manager.

"Jenkins Report" at p.61 re disqualification criteria, but arguably equally applicable in this context.

"Jenkins Report" at p.61.

Minutes of the MRP Advisory Committee, Dec. 21, 1992, at pp.4-5.
Present: Dr, Nigel H Clark, Dr, Ian Connell, Dr. J. T. Sandy (MRP Chairs and Members of the Advisory Committee); Dr, Leonard C. Jenkins, MRP Registrar; Heather Green, Legal Advisor, Office of the Board of Governors.
Minutes of the MRP Advisory Committee, Dec. 21, 1992, at pp.5-6.
Present: Dr. Nigel H Clark, Dr. Ian Connell, Dr. J. T. Sandy (MRP Chairs and Members of the Advisory Committee); Dr. Leonard C. Jenkins, MRP Registrar; Heather Green, Legal Advisor, Office of the Board of Governors.

Gallagher Report, p.60.

Gallagher Report, p.60.

MRP meeting at Commission office, afternoon session, April 1st 28th, 1998, 
In attendance: Judge Gill; Patrick Lewis; Gerry Stoney; Sharon Samuels; Leigh Sheardown, Current Registrar; Dave Martin, Past Registrar; Jan Dicks, Manager.

"Jenkins Report" at p.61.

"Jenkins Report" at p.63. Under s.59(1) of the Act, no Specialist can sit on an MRP who has treated the worker, acted as a consultant in the worker’s treatment, or is a partner or practices together with a Specialist who has treated the worker. Partners who practice medicine together are also restricted from sitting on the same panel.

Published policy clarifies that "the exclusions in Section 59(1) operate in addition to the common law rules of bias. This means that Specialist members are not permitted to sit on a Panel where they have a relationship with a person concerned in the claim which gives rise to a reasonable apprehension of bias. This includes relationships with other members of the Panel, and any other officer of the Board who may have been involved with the claim." -- RSCM #103.53.

Minutes of the MRP Advisory Committee, Dec. 21, 1992, at pp.4-5.
Present: Dr. Nigel H Clark, Dr. Ian Connell, Dr. J. T. Sandy (MRP Chairs and Members of the Advisory Committee); Dr. Leonard C. Jenkins, MRP Registrar; Heather Green, Legal Advisor, Office of the Board of Governors.

Minutes of the MRP Advisory Committee, Dec. 21, 1992, at pp.5-6.
Present: Dr. Nigel H Clark, Dr. Ian Connell, Dr. J. T. Sandy (MRP Chairs and Members of the Advisory Committee); Dr. Leonard C. Jenkins, MRP Registrar; Heather Green, Legal Advisor, Office of the Board of Governors.

Gallagher Report, p.60.

"Jenkins Report" at p.61.

Minutes of the MRP Advisory Committee, Dec. 21, 1992, at pp.4-5.
Present: Dr. Nigel H Clark, Dr. Ian Connell, Dr. J. T. Sandy (MRP Chairs and Members of the Advisory Committee); Dr. Leonard C. Jenkins, MRP Registrar; Heather Green, Legal Advisor, Office of the Board of Governors.

Minutes of the MRP Advisory Committee, Dec. 21, 1992, at pp.4-5.
Present: Dr. Nigel H Clark, Dr. Ian Connell, Dr. J. T. Sandy (MRP Chairs and Members of the Advisory Committee); Dr. Leonard C. Jenkins, MRP Registrar; Heather Green, Legal Advisor, Office of the Board of Governors.

Gallagher Report, p.60.

Gallagher Report, p.60.

Gallagher Report, p.31.


Brake report, p.7.

“Medical Review Panel Department 1996 Annual Report to the Panel of Administrators”, introductory page. The annual report also noted that “the fields of expertise range from occupational medicine to orthopedic surgery (most frequently used in 1996).”

MRP meeting at Commission office, morning session, April 1st 28th, 1998, 
In attendance: Judge Gill; Patrick Lewis; Gerry Stoney; Sharon Samuels; Judy Olson MAO; Dianna Brett MAO; Dave Haralds, MAO; Helen Ukranitz, Level II Clerk; Barb Charron, Client Service Representative; Francine McCullough, Panel Scheduling.
In the afternoon session it was revealed that Jenkins does not act as a Chair and one of the 12 acting Chairs has recently retired so that there are only 11 acting Chairs now.

MRP meeting at Commission office, afternoon session, April 1, 28th, 1998,
In attendance: Judge Gill; Patrick Lewis; Gerry Stoney; Sharon Samuels; Leigh Sheardown, Current Registrar; Dave Martin, Past Registrar; Jan Dicks, Manager.

MRP meeting at Commission office, morning session, April 1, 28th, 1998,
In attendance: Judge Gill; Patrick Lewis; Gerry Stoney; Sharon Samuels; Judy Olson MAO; Dianna Brett MAO; Dave Haralds, MAO; Helen Ukranitz, Level II Clerk; Barb Charron, Client Service Representative; Francine McCullough, Panel Scheduling.


The Royal Commission was told by Sheardown that:
The Narrative is a large part of the fees paid to doctors. The fee is $488.00 for the first three hours and $140.00 per hour thereafter. The average cost of a panel is $5000.00 to $6000.00. In 1997 it was $5778.00. There are 28 staff in the registrar's office. In 1996 MRPs fees were very high, despite the fact that only a hundred plus panels were held. It may be that because they had less work, they took longer with what they were given.

--MGRP meeting at Commission office, afternoon session, April 1 28th, 1998,
In attendance: Judge Gill; Patrick Lewis; Gerry Stoney; Sharon Samuels; Leigh Sheardown, Current Registrar; Dave Martin, Past Registrar; Jan Dicks, Manager.

Jenkins Report,  p. 67.

Gallagher Report, p.32.

" Re: Interpretation of Sections 58 through 65", memorandum to David Martin, Registrar, Medical Review Panel; from Laurel Courtney, Barrister and Solicitor, Legal Services, Dated May 7, 1997 at p.4.

"Royal Commission on Workers' Compensation Meeting with the Medical Review Panel Advisory Committee (Chairs)", January 21, 1998. Notes taken by Karen Ryan. Present: Dr. Ian Connell, Dr. Nigel Clark, Dr. Leonard Jenkins, Judge Gurmail Gill, Terry Robertson, Gerry Stoney, Patrick Lewis, Karen Ryan, at p.1 &3.

Jenkins also offered the following comments and recommendations on this topic:

The Medical Review Panel should be bound by the Board’s findings of non-medical facts, since an opportunity to dispute these findings was available to the worker and employer or their representatives prior to the non-medical facts being finalized by the MAO for the Panel. The MAO is in the best position to investigate new facts and reach a decision. It is current practice to investigate new evidence and determine facts in the preparation of the Statement. In some cases this involves sending the file back to the Compensation Services Division for clarification, etc. The normal appeal rights would apply to the MAO’s determination.

In the event that "new non-medical facts" or "disputed non-medical facts" emerged curing the examination (history taking/physical examination) by the Panel the Chairman of the Panel should consult the MAO on the case and the Registrar in order to review the result issue.

Any "disputed" facts should be resolved prior to the Panel examination. All parties have the opportunity to respond to the Statement and resolve any disputes before the Panel examination takes place. The Panel should base its conclusions on the facts as presented in the Statement. If the Panel questions the facts, it should refer the matter back to the MAO. If the dispute is not resolved regarding the facts, the MAO’s decision is appealable to the Review Board.

The MAO should be responsible for reviewing out to obtain any additional medical records that might be relevant to the decision in dispute and are not found unclaimed file...

"The MAO has reviewed and is familiar with the entire claim file while preparing the Statement of Foundational Non-medical Facts and is familiar with the general medical history. The MAO is thus aware that, for example, a worker has been seen by a physician for a longer period than shown on the claim file, which usually occurs between the time benefits were terminated and an appeal process is initiated and finalized. However, the review process is time-consuming, resulting in a reduced number of appeals being handled by the MAO.

It is acceptable that the Panel Chairman continue to be provided with the "split file". A "split file" contains all relevant documents for the Panel’s review. To provide the whole file in every case would result in unnecessary paper mass and irrelevant correspondence that does not affect the medical issue before the Panel and would delay the Panel’s review of the matter. The MAO may deem that other information is relevant and forward this to the Panel. Of course, the Panel should be able to request the whole file, if felt necessary. Some information not sent to the Panel could or may be considered an opportunity to pre-judge.

Particular care must be taken with respect to claims on which a previous Panel’s Certificate has been declared null and void. In such cases, the documents sent to the new Panel must be closely scrutinized to ensure that they do not provide an opportunity for a real apprehension of bias."
Brake outlined three options which were considered for resolving the problem:

1. Maintain the current practice of preparing Statements in all cases, prior to the MRP Exam.
2. Abolish the statements and rely on claims adjudicators decisions, WCRB findings or Appeal Division decisions to represent the non-medical facts. Allow for referral back to the adjudicative body decided the matter where clarification is required on a non-medical fact.
3. Develop a modified Statement for some cases, depending upon the complexity of the non-medical facts. The modified Statement would include:
   - a description of the *bona fide* medical dispute;
   - the findings of the claims adjudicator, WCRB and Appeal Division;
   - the issues posed as questions to be certified by the MRP; and
   - any related wage loss periods.

Brake noted that the MRP staff fully supported option No. 1, that the Chairs were of the view that the Statement, as it then existed was "valuable in their decision-making," should be prepared in all cases and should be "more comprehensive and less detailed."

--Brake report, pp.9, 10, 11.


Gallagher Report at p.23.


"Royal Commission on Workers’ Compensation Meeting with the Medical Review Panel Advisory Committee (Chairs)", January 21, 1998. Notes taken by Karen Ryan. Present: Dr. Ian Connell, Dr. Nigel Clark, Dr. Leonard Jenkins, Judge Gurmail Gill, Terry Robertson, Gerry Stoney, Patrick Lewis, Karen Ryan, at pp.2 & 3.

MRP meeting at Commission office, morning session, April 28th, 1998,
In attendance: Judge Gill; Patrick Lewis; Gerry Stoney; Sharon Samuels; Judy Olson MAO; Dianna Brett MAO; Dave Haralds, MAO; Helen Ukranitz, Level II Clerk; Barb Charron, Client Service Representative; Francine McCullough, Panel Scheduling.

MRP meeting at Commission office, afternoon session, April 28th, 1998,
In attendance: Judge Gill; Patrick Lewis; Gerry Stoney; Sharon Samuels; Leigh Sheardown, Current Registrar; Dave Martin, Past Registrar; Jan Dicks, Manager.


Brake report, p.15.

"Medical Review Panel Department 1996 Annual Report to the Panel of Administrators" at p.11.

The Royal Commission was told that each Chair would handle it slightly differently and acts it is hard to tell exactly what happens because the MRP is independent and outside of the system. (Under section 61(5) "the panel must determine its own procedure"). Sheardown stated that such a meeting probably happens subsequent to the medical exam and that it may depend on the complexity of the case. In a more complicated one there could be a few meetings prior.
MRP meeting at Commission office, morning session, April 128th, 1998,
In attendance: Judge Gill; Patrick Lewis; Gerry Stoney; Sharon Samuels; Judy Olson MAO;
Dianna Brett MAO; Dave Haralds, MAO; Helen Ukranitz, Level II Clerk; Barb Charron, Client
Service Representative; Francine McCullough, Panel Scheduling.

MRP meeting at Commission office, afternoon session, April 128th, 1998,
In attendance: Judge Gill; Patrick Lewis; Gerry Stoney; Sharon Samuels; Leigh Sheardown,
Current Registrar; Dave Martin, Past Registrar; Jan Dicks, Manager.

The Royal Commission was told that each Chair would handle it slightly differently and acts it
is hard to tell exactly what happens because the MRP is independent and outside of the system.
(Under section 61(5) "the panel must determine its own procedure"). Sheardown stated that
such a meeting probably happens subsequent to the medical exam and that it may depend on
the complexity of the case. In a more complicated one there could be a few meetings prior.

"Royal Commission on Workers’ Compensation Meeting with the Medical Review Panel Advisory
Committee (Chairs)", January 21, 1998. Notes taken by Karen Ryan. Present: Dr. Ian Connell, Dr.
Nigel Clark, Dr. Leonard Jenkins, Judge Gurmail Gill, Terry Robertson, Gerry Stoney, Patrick
Lewis, Karen Ryan, at p.1 &3. [SJS: review terms of reference to, confirm Connell's
description?]

Jenkins Report, p.

Minutes of the MRP Advisory Committee, Dec. 21, 1992, at p.3.
Present: Dr, Nigel H Clark, Dr, Ian Connell, Dr. J. T. Sandy (MRP Chairs and Members of the
Advisory Committee); Dr, Leonard C. Jenkins, MRP Registrar; Heather Green, Legal Advisor,
Office of the Board of Governors.

"Jenkins Report" at p.67.
Received by Royal Commission January 21, 1998. [SJS: Pick up copy from office - review]
"Jenkins Report" at p.62.
Gallagher Report, p.64.

Present: Dr, Nigel H Clark, Dr, Ian Connell, Dr. J. T. Sandy (MRP Chairs and Members of the
Advisory Committee); Dr, Leonard C. Jenkins, MRP Registrar; Heather Green, Legal Advisor,
Office of the Board of Governors.

Gallagher Report, p.32.
Gallagher Report, pp.31 & 32.
Gallagher Report, p.50.
Gallagher Report, p.61.
Gallagher Report, p.63.

MRP meeting at Commission office, morning session, April 128th, 1998,
In attendance: Judge Gill; Patrick Lewis; Gerry Stoney; Sharon Samuels; Judy Olson MAO;
Dianna Brett MAO; Dave Haralds, MAO; Helen Ukranitz, Level II Clerk; Barb Charron, Client
Service Representative; Francine McCullough, Panel Scheduling.

MRP meeting at Commission office, afternoon session, April 128th, 1998,
In attendance: Judge Gill; Patrick Lewis; Gerry Stoney; Sharon Samuels; Leigh Sheardown,
Current Registrar; Dave Martin, Past Registrar; Jan Dicks, Manager.
A resolution of the Panel of Administrators, dated January 14, 1997 provides for a yearly performance evaluation process for the MRP Registrar. Angela Weltz is in the process of determining whether such evaluations do in fact take place.

"Jenkins Report" at p.62.
Jenkins Report, p. 69.
Gallagher Report, p.61.
Jenkins Report, p.57.
Jenkins Report, p.64.
Jenkins Report, p.69.
Gallagher Report, p.22.
Gallagher Report, p.63.
"Submission to the Royal Commission on the Workers Compensation Board from the Chairs of the Medical Review Panels", prepared by the Medical Advisory Committee of the MRP on behalf of the Chairs of the MRP's. October 1997 at p. 2.
For example, in 1996, Gallagher recommended that the following steps be taken to reduce or eliminate delays in the MRP process:

Eliminating ambiguities and voids in legislation
Gallagher recommended that ambiguities and voids in sections 58-66 of the Act be modified to eliminate imprecision within the MRP system. For example, in s.59(1), s.60, 61(7), s.63(2), s.63 (4), which use such phrases as "within a reasonable period of time" and "...or the further time that the Board considers necessary."

Improving management and quality assurance
Improved management, quality assurance, monitoring and control mechanisms in the system could reduce time delays. Gallagher concluded that time delays may be attributed to a lack of "even the most basic and fundamental requirements of management control and direction" including a "clear vision of the role and purpose of the system and department", "a record of objectives and goals" and an "administrative action plan with standards and requirements for performance." "Staff training/ retraining is addressed only on an ad-hoc basis." [p.18-22]

Increasing quality and quantity of adjudicative staff
Gallagher asserted that certain time delays "are related to adjudicative staffing levels and performance":

- Some physician adjudicators have unacceptably long turnaround times for certificates.
- Written narratives produced by some MRP Chairs are not required under the Act and are excessively long.
- Some certificates are unclear, incomplete, or deal with irrelevant matters.

Gallagher recommended increasing the number of MRP Chairs from 15 to 22. [, p.31-32, p.44-45. See also recommendations #13-23, p.60-61].

Improving training, direction and control of physicians
Gallagher concluded that the failure of the system to direct and control adjudication by physicians contributes to time delays. The following concerns have been highlighted:

- inadequate training & orientation materials for physicians;
- lack of a critical definition of the jurisdiction of MRPs;
- lack of "prescribed metes and bounds for the independence of MRPs";
- lack of "role definition, objectives, controls, standards and monitoring of performance, effective communications, and mechanisms for accountability";
- absence of planning and control over matters relating to adjudication by physicians;
- inadequate linkage and coordination between administration and physician adjudicators; and
- ineffective communication between administration and physician-adjudicators. [p.50-52, Also see recommendations #32-#33].

Replacing obsolete processing technology and systems for file control and management

"The MRP department does not have the benefit of an effective case management system." Its computerized system is so "ineffective" and "obsolete" that "it hinders the efficient processing of cases." The need for an up to date system is "urgent". Such a system could:

- electronically monitor the progress of case files;
- provide flags to time limits;
- call attention to delays; and
provide management tools (e.g. re: caseload statistics, performance measurements, mail merges, scheduling).
Gallagher report, p.34-36. See also recommendations #24-#25, p.61-62.

In 1994, former MRP registrar Weldon Brake commented that the following initiatives were "being pursued and implemented" to resolve the problem of delays:

- having specialties designated by the Registrar at the beginning of the process;\textsuperscript{157}
- initiating employer/worker nominations for Specialists at the beginning of the process;
- scheduling of the panel examination date as soon as the nominations have been completed;
- installation of a new computer system to facilitate the scheduling (As will be discussed below, this has not yet been implemented).
- seeking community feedback on "the preliminary handling of appeals, scheduling, professional conduct of panel examinations, and Certificate/Narratives issued by the Medical Review Panels;"
- development of a separate questionnaire for Specialists and Chairman requesting input in feedback regarding more effective scheduling of panels "in order to eliminate the backlog problem and reduce delays in the Medical Review Panel process;"
- Contacting the BCMA to requests additional Specialists to serve on Medical Review Panels throughout BC;
- reviewing a more integrated scheduling approach; and recruiting an additional Scheduling Clerk

\textsuperscript{158} "First Backlog Report to the Chairman and Board of Governors" by A. Weldon Brake," (hereafter the "Brake report," Dec. 1994, p.9.

Present: Dr, Nigel H Clark, Dr, Ian Connell, Dr. J. T. Sandy (MRP Chairs and Members of the Advisory Committee); Dr, Leonard C. Jenkins, MRP Registrar; Heather Green, Legal Advisor, Office of the Board of Governors.

\textsuperscript{159} "Medical Review Panel Department 1996 Annual Report to the Panel of Administrators" at p.4.

\textsuperscript{160} "Medical Review Panel Department 1996 Annual Report to the Panel of Administrators" at p.1.

\textsuperscript{161} "Medical Review Panel Department 1996 Annual Report to the Panel of Administrators" at p.6.

\textsuperscript{162} "Medical Review Panel Department 1996 Annual Report to the Panel of Administrators" at p.6.

"Medical Review Panel Department 1996 Annual Report to the Panel of Administrators” at pp.10 & 11. I am given to understand there was a belief that discontinuing the Statement [of Foundational Non-medical Facts] for every case, represented the elimination of the major source of time delays, and that the number of MAO’s required (the MAO’s produced the Statements) could immediately be reduced from 7 to 2, without waiting to prove the results. It is my opinion that these matters were not adequately examined before the decisions were made to eliminate the Statement and reduce the number of MAO’s. When considered in light of the number of undecided cases within the MRP system, and the continuing concern about the [average number of days] statistics, the timing of the downsizing of MAO staff seems to defy reason and logic. In terms of the performance of administrative functions within the MRP system, the engine that drives productivity of the system is the MAO... without adequate staffing to system can be so overwhelmed by its caseload that it becomes totally dysfunctional. In my view, the MRP has become dysfunctional and I believe this situation is a direct result of the reduction in the number of MAO is from 7 to 2. ...Even if that change in process should prove to be a significant step in streamlining the MRP system and eliminating time delays, the statistics show that the reduction in the number of MAO’s was ill time. The return on the investment in MAO’s had not been fully realized -- the department was still staggering under its total caseload.”

--Gallagher, pp.26-29.

Contained in the 1996 WCB Annual Report, at p.15.

"Submission to the Royal Commission on the Workers Compensation Board from the Chairs of the Medical Review Panels", prepared by the Medical Advisory Committee of the MRP on behalf of the Chairs of the MRP’s. October 1997 at p. 3.


Note: A similar but updated graph may be found at p. 8 of the 1996 MRP Annual Report. Reproduction was impossible due to poor image quality


Jenkins Report at p.10.

Jenkins Report at p.55.

Jenkins Report at p.65.

Jenkins Report at p.69.


Contained in 1996 WCB annual report, p.15.


"MRP Department 1998 Business Plan”, p.9. Note that the AND goal appears at first glance to have been increased in 1998 to 180 days, as compared to the 120 day AND target described in the 1996 MRP annual report. However, this may not actually be the case because the AND was defined as "the average number of days an appeal takes from opening to closure" in 1998, as opposed to "the processing time from when an appeal is initiated to when it is sent to a panel of physicians" in 1996.
The Act and policy also contains a number of specific time limits for completing the MRP process:

- Under s.58(3), a worker has **90 days** from the finding or decision of the WCB, (i.e. WCB claims adjudicator or the Appeal Division) or the WCRB to initiate an appeal to an MRP.
- Under s.58(4), an employer has **90 days** from the finding or decision of the WCB, (i.e. WCB claims adjudicator or the Appeal Division) or the WCRB to initiate an appeal to an MRP.

> "Where both the request and the physician’s certificate are received within **90 days** of the medical decision of the Board and the certificate is rejected [on the basis that it is not a medical issue] within this initial 90 days, the appellant will be given:
> (a) the remaining time in the initial 90 day period to submit a second medical certificate for consideration under s.58(3) or s.58(4), and
> (b) a further 90 days (following the first 90 days) to submit a further certificate(s), or clarification from his physician under s.58(5)."

- Under s.59(3), the WCB must appoint the Specialists nominated as members of the MRP (provided the Specialists accept) **within 18 days** of the receipt of the nominations.

> "A covering letter (SF1) and a copy of the statement of non-medical facts (where one has been prepared) are sent to the worker, with a copy to any representative, requesting that the worker advise the Board of any disagreements to the statement **within 3 weeks**. A request for an extension of time to respond to the statement from either the worker or representative will be provided on request.
...A covering letter (SF2) and a copy of the statement (where one has been prepared) are sent to all employers, and any representatives, who have been itemized in the statement, requesting that the employer(s) advise the Board of any disagreements to the statement **within three weeks**. If objections to the statement are received, the Medical Appeals Clerk will provide the other party with a copy of the objections and allow **3 week period** for reply..."

- Section.61(7) of the Act, which provides that: "[within 18 days or the further time that the board considers necessary] of the receipt of the certificate from the Chairman of the medical review panel, the board shall review the claim and send a true and complete copy of the certificate to the worker, to the physician whose certificate accompanied the request under s.58(3) or (4) and to the employer.”

Gallagher Report, p.11, p.57-58, recommendation #5.