ALA QLD Submission of Comments to OIR

Submissions to OIR re: (a) Injured worker medical consultations + additional consent and (b) 2 x Rehabilitation Guidelines

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Protecting and promoting justice, freedom and the rights of the individual.

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Who we are

The Australian Lawyers Alliance (ALA) is a national association of lawyers, academics and other professionals dedicated to protecting and promoting justice, freedom and the rights of the individual.

We estimate that our 1,500 members represent up to 200,000 people each year in Australia. We promote access to justice and equality before the law for all individuals regardless of their wealth, position, gender, age, race or religious belief.

The ALA is represented in every state and territory in Australia. More information about us is available on our website.[1]

The ALA office is located on the land of the Gadigal of the Eora Nation.

[1] www.lawyersalliance.com.au.

Introduction

ALA has been asked to comment upon two classes of draft documents. The requests to comment arrived separately from OIR. As the issues traversed by both cohorts of documents are linked, ALA has one submission encompassing both cohorts. It appears below.

Our submission

We would welcome the opportunity to meet to discuss matters further.

1. <u>The draft "Injured worker medical consultations", and a draft additional consent.</u>

The request for comment on these documents came from Ms Hillhouse at OIR under cover of email dated 15 October 2021 at 2.10pm.

We will comment on each draft document separately:

(a) **"Injured worker medical consultations" draft.**
This document is based upon a WA Regulator document which has been in use for several years.

Members of ALA have for many years been expressing concern about some employers and self-insurers misleading, coercing and bullying injured workers about their rights in respect of medical treatment and consultations. This tends to occur more often with self-insurers. A document of this type is overdue and welcome. It will be important that the document is backed up with action where its terms are not adhered to by employers and/or self-insurers. We consider that there is a high risk of that occurring.

ALA supports the content of the document with these additions and exceptions:

(i) At the end of the section entitled "Employer attendance at medical consultations" add as new paragraph as follows:

"The fact that medical attendances may be paid for by a workers' compensation insurer is also no basis for seeking to attend at a private and confidential medical consultation. Action may be taken against employers who seek to play any role in participating in such private medical or allied health meetings."

(ii) Delete all of the "Case conferencing" section for the reasons set out below.
(iii) Delete all of the "Medical authorities" section for the reasons set out below.
(iv) Replace those deletions with:

"At the commencement of the worker's claim, each worker has signed a consent which authorises doctors, health authorities, allied health providers, rehabilitation providers to disclose to Workcover Queensland and its agents any information about my medical history relevant to the worker's claim. Workcover routinely obtains and evaluates such information relevant to the claim, and monitors new information as it is produced. Workcover also complies with legal privacy

obligations. Our employer return to work guide **[link]** provides further guidance about return to work options and your responsibilities. For some workers, a case conference involving your representative, the worker and their representative and possibly allied health professionals and doctors may be desirable. In such cases, if there is additional information relevant to the worker's claimed injury which is needed, that will be considered before the case conference occurs."

(b) The additional consent form.

ALA strongly opposes the use of this document or any similar iteration of it, because:

(i) The WCRA already imposes clear obligations upon injured workers in respect of disclosure of relevant information,

(ii) Those obligations find expression in the consent contained within the claim form, referred to above. The consent explicitly authorises the provision of "any information about [the worker's] medical history **relevant to this claim**." [our emphasis],

(iii) The additional consent is in our view a solution seeking a problem. There is no evidence that the existing consent is not fit for return to work purposes,

(iv) There is no sound rationale for allowing others access to irrelevant medical material,

(v) Any consent which would permit of the worker's entire medical history to be disclosed to employers and insurers harbours many unacceptable risks, including:

- Many, perhaps most people have matters in their medical history which they would regard as highly sensitive,
- Some employers have no respect for privacy and confidentiality, irrespective of assurances given on the draft consent. Our members see cases where what has occurred in the Workcover process, including discussion of medical issues, has been the subject of discussion, gossip and innuendo later in the broader workplace. To add to relevant medical material other irrelevant, and in many case deeply personal and sensitive information, heightens those risks. Such improper disclosure of medical information distresses workers and engenders deep distrust not only of the employers, but others perceived to be part of the system which permitted the disclosure to occur. It disrespectful to injured workers and antithetical to the objects of the WCRA.
- The disclosure of irrelevant medical information provides Workcover, self-insurers and employers with an unjustifiable, unfair forensic advantage in the litigation process. Relevance has long been the touchstone for disclosure in the Courts. Rightly so. There is no justification, included an asserted benefit to RTW objectives, to allow Workcover, insurers or employers to go on fishing expeditions, trawling through sensitive, irrelevant information.

(vi) The fact that the draft consent is cast as "optional" will not resonate with many workers. Many will perceive it as being required as a matter of law, particularly without the benefit of a lawyer, which is often the case during the statutory phase.

The proposed document should in our view be dispensed with.

2. **The documents upon which comment was sought under cover of an email from Ms Fiona Martin dated 18 November 2021 at 4.20 pm.**

Our comments upon those draft documents appear below.

1. Rehabilitation terms, roles and responsibilities document:

    a. Needs to explain the term "key stakeholders" which is used throughout the other two guidelines. The document entitled "Rehabilitation and return to work plan guideline – for insurers" has a definition on page 5 which is probably suitable.

    b. Terms rehabilitation and return to work co-ordinator – so this is used specifically in the WCRA where certain employers must have such a co-ordinator, either employed or contracted. However, in these documents they tend to refer to this coordinator far more broadly, what I would think is akin to "case management". Therefore, either they need to clarify this and/or specify that a worker has a right to choose their own medical and allied health practitioners, including a coordinator.

    c. We commend the proposition that suitable duties should be meaningful. This will be contextual; but age, education, training and experience are all factors to be considered. Our members routinely hear reports from workers placed in meaningless positions, with the worker often perceiving that the underlying rationale was to protect superiors' "no LTI" financial bonuses.

    d. Page 4 SDP at paragraph 7 – stipulates the SDP must be signed off by treater "if outlined on the Work capacity certificate…". We suggest that all SDP, RTW programs must be reviewed by, and signed off by, a *treating* medical or allied health practitioner.

    e. Page 5 – Worker – paragraph 2 states the worker "should" be consulted. I think the worker "must" be consulted on development of a rehab plan. No, or deficient worker consultation almost guarantees a lack of worker buy-in.

2. Accredited rehabilitation and return to work program guideline – for insurers:

    a. Page 3 – intro – end of 2nd paragraph should include "or maximise independent functioning" because a rehab program is not just about RTW under the WCRA. If not possible to RTW, then the obligation is to maximise independent functioning.

    b. Page 5 – rights and responsibilities – it is vital that this document clearly states that the worker has a right to choose their own medical and allied health providers, that the employer cannot influence this decision, and that the worker must be advised that they do not have to attend an employer doctor (if the employer offers such a service). The issues of company doctor lack of independence and behaviours has been well-ventilated with OIR in the past.

    c. Pages 6 – 7 – Rehabilitation and return to work plans – it must be made clear that such plans must be reviewed by, and signed off by, a *treating* medical or allied health practitioner, and where applicable, the appointed case manager.

3. Rehabilitation and return to work plan guideline – for insurers:

    a. Page 5 last dot point – this goes back to my point 1(b), if the insurer proposes using a case manager to coordinate services, then the worker ought to have a

choice in this the identity of the case manager, including being able to nominate their own.

b. Page 6 – elements of the RRTW plan, dot point 2 – details of other health conditions – is concerning including for the reasons set out above on the additional consent. Relevance must always be the touchstone.

c. Page 6 – elements of the RRTW plan, penultimate dot point – sign off, again clarifying this is to be signed off by treating practitioner and if applicable the case manager.

There also needs to be confirmation from OIR that, if there are any issues/complaints by worker or worker is requested to do anything outside the scope of the plan, they are not required to do that, and should be encouraged to report to employer, insurer and treater.

Finally, we consider that Workcover has under-utilised external case managers in the RTW context for many years. Skilled case managers can be hugely valuable in identifying suitable duties, and being a trusted liaison point between injured workers, their treating practitioners, the employer and insurer. Our members have seen the external case management model produce outstanding outcomes in the CTP and NIIS contexts; and we believe that an opportunity exists to improve RTW outcomes by a more proactive and structured approach to external case management on the workers' compensation context.

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Conclusion

Should you have any questions about any of the comments above, please do not hesitate to make contact.

Sarah Grace

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Australian Lawyers Alliance