Date: 19990511
Docket: C.A. 152313

NOVA SCOTIA COURT OF APPEAL

Cite as: Bacich v. Braithwaite, 1999 NSCA 77

Roscoe, Bateman and Cromwell, JJ.A.

BETWEEN:

JIM C. BACICH, GREG A. BLANCHARD, REINHOLD M. ENDRES, Q.C., GEORGE L. FOX, GRANT VAUGHN, BILL McKEE, and LISA MORRIS, all as Trustees of the NOVA SCOTIA PUBLIC SERVICE LONG TERM DISABILITY PLAN TRUST FUND	)	Colin D. Bryson for the appellant
Appellants	)	
- and -	)	
DAVID BRAITHWAITE	)	John W. Morgan for the respondent
Respondent	)	
	)	Appeal heard: April 9, 1999
	)	Judgment delivered: May 11, 1999

THE COURT: Appeal dismissed per reasons for judgment of Cromwell, J.A.; Roscoe, J.A. concurring; Bateman, J.A. dissenting.

BATEMAN, J.A.: (Dissenting)

[1] This is an appeal by the Trustees of the Nova Scotia Public Service Long Term Disability Plan Fund from an Order of Justice Frank Edwards of the Supreme Court dismissing the Trustees' application to Strike the respondent's Statement of Claim.

Background:

[2] The respondent, David Braithwaite, is a member of the Correctional Officers bargaining unit of the Nova Scotia Government Employees Union (NSGEU). As such, his relationship with his employer, the Government of Nova Scotia is governed by a Collective Agreement. The Collective Agreement provides at Article 15(1) that the employees are to be covered by the Nova Scotia Public Service Long Term Disability Plan (the "Plan"). The coverage under this Plan is available to employees through the various collective agreements between the Province and the NSGEU. It is co-sponsored by the Province and the NSGEU. The Maritime Life Company is the Plan administrator.

[3] Mr. Braithwaite was suffering from a clinical depression and, as of November 6, 1994, it was determined that he was "disabled". Following an "elimination period" he became eligible for LTD benefits on March 23, 1995. He received benefits from that date until July 1, 1996. In the fall of 1995 it was also determined that Mr. Braithwaite was disabled due to bi-lateral carpal tunnel syndrome. He underwent corrective surgery for that condition in October and December 1995. The Plan administrator decided that as of July 2, 1996, Mr. Braithwaite was no longer disabled. His benefits were

terminated.

[4] Mr. Braithwaite appealed the decision of the Plan administrator to a medical hearing board. His appeal was denied. He then commenced an action in the Supreme Court against the Trustees of the Plan. In his Statement of Claim he seeks payment of arrears of LTD benefits, ongoing benefits, punitive, special and general damages as well as costs. He claims, *inter alia*, bad faith on the part of the Trustees in denying him benefits under the plan.

[5] The Trustees applied to strike the Statement of Claim pursuant to **Civil Procedure Rule 14.25**. Justice Edwards dismissed the application. The Trustees have appealed.

Issues:

[6] The Trustees frame the issues as follows:

(i) Is Mr. Braithwaite's claim for disability benefits *res judicata*, having been decided by the medical appeal process?

(ii) Can Mr. Braithwaite's claim of bad faith succeed if the claim for disability benefits has been finally decided against him.?

Analysis:

[7] The appellants' application to strike the Statement of Claim was brought pursuant to **Civil Procedure Rule 14.25(b)** and **(d)**:

> **14.25** (1) The court may at any stage of a proceeding order any pleading, affidavit or statement of facts, or anything therein, to be struck out or amended on the ground that,
>
> (a) it discloses no reasonable cause of action or defence;
>
> (b) it is false, scandalous, frivolous or vexatious;
>
> (c) it may prejudice, embarrass or delay the fair trial of the proceeding;
>
> (d) it is otherwise an abuse of the process of the court;
>
> and may order the proceeding to be stayed or dismissed or judgment to be entered accordingly.
>
> (2) Unless the court otherwise orders, no evidence shall be admissible by affidavit or otherwise on an application under paragraph (1)(a).
> (emphasis added)

[8] In **Curry v. Dargie** (1984), 62 N.S.R. (2d) 416, at p.429, Macdonald J., writing for this Court, summarized the law under **Rule 14.25**:

> The law is quite clear that the summary procedure under *Rule 14.25* can only be adopted where the claim is, on the face of it, absolutely unsustainable. Thus, if it is clear beyond any doubt that an action cannot possibly succeed there is no reason for refusing to strike out the statement of claim. The mere fact, however, that the plaintiff appears unlikely to succeed at trial is no ground for striking out the statement of claim. In *O'Donnell v. Scallion* (1892), 24 N.S.R. 345, Mr. Justice Graham said at p. 355:
>
> > . . . This power to strike out pleadings under this rule should, it seems, be exercised with great caution. Unless the court is satisfied that a pleading discloses no reasonable or probable answer it will not be struck out. The mere fact that the party pleading it is not likely to succeed at the trial is no ground for striking it out; *Dadswell v. Jacobs*; 34 Ch. D., 284, *Boaler v. Holder*, 54 L.T.N.S. 298.

[9] In **Haase v. Vladi Private Islands Ltd.** (1990) 96 N.S.R. (2d) 323, Macdonald, J., again writing for this Court said:

> In considering an application to strike out a pleading it is not the court's function to try the issues but rather to decide if there are issues to be tried. The power to strike out pleadings is to be used sparingly and where the statement of claim raises substantial issues it should not be struck out. (See: *Seacoast Towers Services Ltd. v. MacLean* (1986), 75 N.S.R. (2d) 70 (C.A.) and *Cuddy Food Products Ltd. v. Associated Freezers of Canada Inc. et al.* (1987), 80 N.S.R. (2d) 412, affirmed 1988, 82 N.S.R (2d) 406.)

(Emphasis added)

[10] In dismissing the application Justice Edwards said:

> In my view, Article 15 places the LTD Plan squarely within the third category noted in *Brown and Beatty*. The Collective Agreement sets forth that employees will be covered by a plan, sets forth the employer's obligation to pay premiums, but does not specifically incorporate the terms of the Plan into the Collective Agreement. As such, the issue of whether or not benefits are to be paid is solely between the employee and the Board of Trustees. The employer does not, under this Collective Agreement, assume liability for non-payment. Had the parties intended to incorporate the Long Term Disability Plan into the Collective Agreement and provide for adjudication of disputes, they would and could have negotiated specific language to this effect. They chose not to, thus leaving the adjudication of such disputes outside the scope of the Collective Agreement and therefore with the Courts.
>
> Mr. Braithwaite's claim for disability benefits therefore falls within the jurisdiction of this Court. Accordingly, the Defendant's application to strike the Statement of Claim on the jurisdictional ground is dismissed.
>
> As noted, the Applicant argues that the claim for disability benefits has been decided by arbitration and is thus ***res judicata***. I simply reject this argument, the medical appeal system is not a final and binding finding. The medical appeal dealt solely with a medical question. It did not deal with a host of matters raised in the Statement of Claim (e.g. whether alternate employment was available to Mr. Braithwaite).
>
> Similarly, I reject the argument that the claim of bad faith cannot possibly succeed. The theory is that a bad faith claim cannot exist in law when the underlying claim for disability benefits has already been denied. In this case, such an argument begs the question about whether or not Mr. Braithwaite's claim was properly denied. This Court will ultimately make that determination and consequently will decide whether or not a bad faith claim can succeed.

[11] The Trustees have not appealed Justice Edward's ruling that the LTD Plan was not a part of the Correctional Officer's Collective Agreement. The denial of benefits is, therefore, not a grievance "with respect to the interpretation or application of the Collective Agreement" and thus is not subject to arbitration under the provisions of the Agreement.

[12] The question before us is whether Justice Edwards erred in finding that the respondent's action raised an issue to be tried?

[13] Entitlement to LTD benefits is predicated upon the employee's "disability" as defined in the Plan:

> 1.(c) "disability"/disabled" means the complete inability, as defined from time to time in *Guidelines* made pursuant to this Plan, of an employee, because of illness or injury, to perform the regular duties of his/her occupation during the applicable elimination period and the next 30 months of any period of disability. Thereafter, an employee remains disabled if he/she is unable to engage in any occupation for remuneration or profit for which the employee is or may become fit through education, training, experience or rehabilitation, which occupations pays not less than 80% of the current rate of the position, class and step he/she held prior to disability.

[14] A member who is denied LTD benefits has a limited right of appeal pursuant to **Section 6** of the LTD Plan which provides in relevant part:

> (1) The applicant for benefits must submit written proof of disability satisfactory to the administrator. The administrator may require that the applicant be examined by an alternate duly qualified medical practitioner of the administrator's choosing.
>
> (2) When the Administrator rules that an employee is not eligible for benefits hereunder, the employee may appeal to the Board of Trustees, who shall arrange a medical appeal hearing, in accordance with *Letter of Understanding #6* attached hereto.
>
> (3) The decision resulting from the appeal shall be final and not subject to further review.
>
> (Emphasis added)

[15] The *Letter of Understanding* referred to in **s.6(2)** directs the Board of Trustees to establish a medical appeal system, and provides that such appeals be on medical grounds only. This "medical appeal system" is set out in the *Medical Appeal Guidelines*. Those of relevance to this appeal are set out below:

> **NOVA SCOTIA PUBLIC SERVICE**
> **LONG TERM DISABILITY PLAN TRUST FUND**
>
> **MEDICAL APPEAL GUIDELINES**
>
> 1. A letter is sent from Maritime Life Assurance Company, the claims administrator, to the insured denying benefits or advising that benefits will terminate. This letter will also advise the claimant of the right to appeal and the appeal procedure.

2. The appellant is entitled to a copy of the documentation on which the decision to deny or terminate benefits is based.

3. The appellant may commence an appeal by writing to the Coordinator, LTD Benefits or the Chair of the Board of Trustees **within 30 days** of the date of the letter from the claims administrator, *or other date that the claims administrator may use*, advising the appellant of the denial or termination of benefits; the letter must set out the specific grounds on which the appeal is to be based. (Dec/97)

4. The appellant must submit all pertinent medical information intended to support his/her appeal to the claims administrator for review by the claims administrator of its decision, prior to the establishment of a Medical Appeal Board. A maximum of two submissions of medical information is permitted (*Nov/96*).

.....

8. The date, time and place for the hearing of the appeal will be determined by the Coordinator, on behalf of the Board of Trustees, upon consultation with all parties.

9. The Medical Appeal Board may consist of one or more qualified medical doctor(s).

10. The Board of Trustees shall designate the chairperson, who will write the Appeal Board's decision.

11. The parties before the Medical Appeal Board are the appellant, the claims administrator and the Board of Trustees.

.....

14. The appellant may present medical evidence in support of his/her appeal, or may be represented by his/her union representative or legal counsel. Costs incurred on account of legal counsel, medical expert testimony or other professional services are the responsibility of the appellant, and are not reimbursed under any circumstances. If the appeal is successful, the appellant may be reimbursed for personal expenses incurred in travelling to the hearing and for costs in acquiring the medical reports/evidence submitted.

.....

18. The Medical Appeal Board is not required to give reasons for its decision.

20. The Medical Appeal Board's decision is final and binding, and not open to judicial review.
(emphasis added)

[16] Notwithstanding that a member is "disabled", he/she may be denied benefits in the circumstances enumerated in **Section 7(3)** of the **Plan**:

(a) disability is suffered as a result of or in the course of participation in the commission of a crime;

> (b) disability is suffered as a result of an act of war, or participation in a riot, unless the employee was disabled in the course of his duties;
>
> (c) disability is self inflicted and intentional;
>
> (d) disability is due to alcoholism or drug addiction, unless the employee is participating in a recognized therapeutic program to correct his/her addiction, and is under the continuous care of a duly qualified medical practitioner;
>
> (e) the employee is not under the continuous care of or fails to follow the prescribed treatment of a duly qualified medical practitioner;
>
> (f) an employee refuses to disclose medical information required by the Plan Administrator or specialists acting for the Plan Administrator;
>
> (g) the employee is on leave of absence on account of pregnancy;
>
> (h) disability occurred at work and is compensable within the meaning of Regulation 72 of the regulations made pursuant to the Civil Service Act;
>
> (i) disability occurred after the employee was placed on layoff status;
>
> (j) disability results from illness or injury which existed within 90 days prior to the date of hire, unless the employee has completed twelve (12) consecutive months of service without any absence from work due to the pre-existing injury or illness;
>
> (k) an employee refuses to be assessed in accordance with the guidelines made pursuant to this Plan, or refuses to participate in a rehabilitation employment program approved by the Trustees, unless the Trustees determine otherwise. (April 6, 1992)

[17] As stated above, **Section 6** provides a final appeal process on medical grounds only where the administrator rules that an employee is not eligible for benefits. There is no provision in the Plan for an appeal where benefits are denied on non-medical grounds. It follows in my view, and the appellant agrees, that where the administrator has denied benefits on non-medical grounds, the claimant may seek redress in the courts. (See **Re: Kimberly Wigginton** - arbitration decision - October 14, 1994, S. Bruce Outhouse, arbitrator)

[18] The letter of July 1, 1996, from the Plan administrator terminating Mr. Braithwaite's

benefits says in the relevant part:

> This is further to our letter of June 20, 1996 and the meeting which was arranged to facilitate your return to work. I have been advised by Noelle Baldwin of Maritime Life that you are not in agreement to the proposal set forth by your employer and Maritime Life which was approved by your treating physician. You advised that you are seeing your specialist next week which will support your inability to return to the program.
>
> Please refer to our letter of April 15, 1996 which indicated to you that at that time your benefits were being reinstated based upon your physical limitations only (bilateral carpal tunnel syndrome). No information at that time or now indicates any limitations regarding a disabling psychiatric illness. We therefore have no alternative but to terminate your benefits immediately as you are not cooperating with the recognized rehabilitation program under the provisions of the Plan Document.
>
> Our decision to terminate your LTD claim may be appealed on medical grounds only, to the Board of Trustees, who will be responsible for the appointment of a formal Medical Appeal Board to hear your medical appeal. . . Your letter requesting a medical appeal must contain the medical reasons for the appeal.
>
> Before the Medical Appeal Board will schedule a hearing date, you will be responsible for supplying medical information which supports your inability to be gainfully employed. . . .
>
> The medical information should include a detailed medical report from a Specialist by whom you have been recently examined; objective medical evidence (ie. Recent and comparative X-ray results, blood work, etc.); consultation reports and hospital discharge summaries; clinical findings; severity of symptoms; specific limitation; the type of treatment provided; including medications and dosages; and a prognosis for return to work.
>
> . . .
>
> (emphasis added)

[19] The respondent says that it is unclear from the administrator's letter whether the denial of benefits is based upon medical or non-medical grounds. Thus there is an issue to be tried.

[20] On July 31, 1996 the administrator received a letter from Mr. Braithwaite advising that he wished to appeal the termination of benefits on medical grounds:

> I am writing this letter in regard to the decision to terminate my L.T.D. claim. I would like to appeal on medical reason (sic). I do not have full detail on my report but I will receive one on my next appointment on July 26, 1996. If you would want to contact my doctor his name, address and telephone number is as follows . . . (emphasis added)

[21] In response to this request and consistent with the **Medical Appeal Rules** a Board was convened to hear the appeal. By letter dated July 20, 1997, Dr. Byron Reid, "the Board" who heard the appeal, advised Mr. Braithwaite that his appeal was denied:

> I am writing to inform you of my decision on your appeal on July 10, 1997.
>
> I am denying your appeal. I recommend that you proceed with training for an alternative position within the Department as outlined by Ms. Carol Anne Axford.

[22] It is the appellants' position that, according to Dr. Reid's decision, Mr. Braithwaite is not "disabled" as defined in the Plan. Although Mr. Braithwaite is entitled to seek the assistance of the court where his benefits are terminated on non-medical grounds, it is a pre-condition to relief, that he be disabled. The court cannot order on-going benefits or find that he was wrongfully denied benefits, as is alleged in the Statement of Claim, in circumstances where Mr. Braithwaite is not disabled. In the language of **Curry v. Dargie**, supra, says the appellant, the action cannot possibly succeed. Dr. Reid's finding is subject to challenge only through judicial review, which process has not been initiated by the respondent.

[23] The respondent says that it is unclear whether in terminating benefits the administrator was of the view that Mr. Braithwaite no longer suffered from medical limitations, or whether benefits were terminated because of his failure to co-operate with a rehabilitation program. The latter would be a termination of benefits within **s.7(3)(k)** of the Plan. Such termination would be one made on "non-medical" grounds and therefore reviewable by the court, not the medical appeal board which is restricted to appeals only

on medical grounds. In my view, this approach does not advance the respondent's position. Mr. Braithwaite chose to appeal the administrator's decision on medical grounds. He has not challenged the decision of the Board through the judicial review process. Dr. Reid is therefore presumed to have acted within jurisdiction. The only reasonable interpretation of his decision is that he has found that Mr. Braithwaite's medical circumstances did not entitle him to benefits. An inability to perform occupational duties because of illness or injury is a precondition to a finding of disability under **s.1(c)**. It matters not whether the administrator denied benefits on medical or non-medical grounds. By appealing to the Board Mr. Braithwaite put his medical status in issue. Dr. Reid concluded from his review on medical grounds that Mr. Braithwaite is not entitled to benefits. In my view it would be impossible for a court to now find that he is entitled to benefits or was wrongly denied benefits, Dr. Reid's decision not having been judicially reviewed.

[24] It is important to keep in mind the consensual nature of the process agreed upon by the employer and the employees. The terms of the LTD Plan, including the definition of disability were the subject of negotiation between the parties to the *Collective Agreement*. The development of the medical appeal system was entrusted to the bipartisan Board of Trustees. Indeed, the parties anticipated that the Board's decision would be "final and binding, and not open to judicial review". (*Medical Appeal Guideline* # 20) This Court in **Bacich v. Holt**, [1998] N.S.J. No. 497, held that judicial review was available but, because the Board was functioning as a consensual tribunal, its decision was entitled to a high level of deference. I acknowledge that the definition of "disability" in

s.1(c) of the **Plan** engages considerations in addition to Mr. Braithwaite's medical condition, in particular, the extent to which he is able to engage in his own or, in the longer term, other employment duties. In my view, however, to assume that the Board had no power to determine such issues would eviscerate the medical appeal process. I reiterate, if the respondent's concern is that Dr. Reid decided issues outside of his mandate, his decision should have been subjected to judicial review. To permit an examination of that issue in this proceeding allows the respondent to circumvent that process, in favour of a more broadly based review.

[25] The material allegations contained in the Statement of Claim are:

(i) that Mr. Braithwaite has been disabled with the meaning of the Plan continuously since November 2, 1992;

(ii) as a result, he was unable to continue at his former employment;

(iii) that the employer could not or would not offer alternate employment at the facility;

(iv) no alternate employment is available to him that would provide at least 80% of the rate of pay of his previous employment;

(iv) the insurer did not make adequate inquiries to determine whether he was medically capable of returning to his former employment;

(v) the insurer did not give proper consideration to the definition of disability in the Plan;

(vi) the insurer failed to fully inform themselves about the availability of alternate employment within the meaning of the definition of "disabled";

(vii) in denying benefits the insurer acted in bad faith.

[26] None of these claims are capable of succeeding where the underlying claim of

disability is not open to review by the court.

[27] Accordingly, in my view, Mr. Braithwaite's action as framed is "absolutely unsustainable". There is no issue to be tried, nor can the Statement of Claim be saved by amendment. I would allow the appeal and strike the Statement of Claim.

Bateman, J.A.

CROMWELL, J.A.:

[28] David Braithwaite (the respondent on appeal) has sued the Trustees of the Nova Scotia Public Service Long Term Disability Plan (the appellants on appeal). The essence of Mr. Braithwaite's claim is that he was and is disabled within the meaning of the Plan and therefore entitled to benefits. He specifically pleads (in paragraph 18 of his statement of claim) that the Trustees did not give proper consideration to the definition of disability as set out in the Plan and, in his affidavit, he states that his complaint is not purely a medical issue.

[29] It is common ground on this appeal that the Disability Plan is not incorporated into the Collective Agreement; it is also common ground that there are two processes for resolution of disputes arising from the Plan. There is a medical appeal system set up pursuant to the Plan which deals with medical grounds only. Other disputes, which are not on medical grounds only, go to the courts. The relevant parts of the Plan and related documents are detailed in the reasons of Bateman, J.A.

[30] Mr. Braithwaite's benefits under the Plan were terminated. He was advised by the Plan administration that he could appeal on medical grounds only. He did and his appeal was denied by the appeal board, Dr. Reid, without reasons. Mr. Braithwaite then commenced this action. Under the medical appeal system, there is no requirement to give reasons. Neither the questions addressed on the medical appeal nor the findings made are before us. There was no application for judicial review of the denial of the medical appeal.

[31] The Trustees applied to the Chambers judge to have Mr. Braithwaite's statement of claim struck out and the action dismissed. To succeed on such an application, the Trustees must show that Mr. Braithwaite's claim is absolutely unsustainable in the sense that it is clear and obvious that his statement of claim does not raise a triable issue. If there are factual issues to be resolved or difficult legal issues to be addressed, the action should not be dismissed at this preliminary stage.

[32] The Chambers judge refused to dismiss the action. The Trustees seek leave to appeal that decision. The Chambers judge's decision was a discretionary one made on an interlocutory application. It should not be set aside unless he applied a wrong principle of law or his order gives rise to injustice.

[33] The crux of Mr. Braithwaite's claim is that he is disabled within the meaning of the Plan. The crux of the Trustees' argument on the appeal is that Mr. Braithwaite's allegation that he is disabled was addressed and finally resolved against him by the medical appeal process provided for in the Plan. While the issue on the appeal may be expressed in various ways, in essence, it is this: Does the fact that Mr. Braithwaite's medical appeal was denied mean that it is clear and obvious that he is not disabled within the meaning of the Plan? The Trustees say the answer is yes. Mr. Braithwaite and the Chambers judge say the answer is no. I agree with Mr. Braithwaite and the Chambers judge.

[34] In order to show that the medical appeal finally resolved the issue of whether Mr. Braithwaite is disabled within the meaning of the Plan, the Trustees must establish three

things:

1. It must be shown that the question of whether the plaintiff was and is disabled within the meaning of the Plan is purely a medical ground. This follows because the medical appeal system, as specified in the Plan, deals with medical grounds only; it does not address other questions.
2. It must be shown that the issue of disability within the meaning of the Plan has been finally and conclusively resolved by the medical appeal process culminating in Dr. Reid's decision; in other words, the issue of the plaintiff's disability within the meaning of the Plan is *res judicata*; and,
3. It must be shown that the medical appeal decision cannot be questioned collaterally in this action.

[35] In my opinion, the Trustees have not demonstrated any of these points with the clarity which would justify summary dismissal of the plaintiff's action at this preliminary stage. I will discuss each of the three points.

1. Is disability within the meaning of the Plan a medical ground?

[36] As noted earlier, it is common ground that the authority to deal with disputes arising under the Plan is divided between the medical appeal process and the courts. The definition of "medical grounds" is key to this division of authority. Appeals on medical grounds only are dealt with by the medical appeal process set up pursuant to the Plan.

Other disputes arising under the Plan go to the courts.

[37] The Plan defines disability as follows:

> 1. (c) "disability"/"disabled" means the complete inability, as defined from time to time in Guidelines made pursuant to this Plan, of an employee, because of illness or injury, to perform the regular duties of his/her occupation during the applicable elimination period and the next 30 months of any period of disability. Thereafter, an employee remains disabled if he/she is unable to engage in any occupation for remuneration or profit for which the employee is or may become fit through education, training, experience or rehabilitation, which occupations pays not less than 80% of the current rate of the position, class and step he/she held prior to disability. (emphasis added)

[38] What constitutes a "medical ground" is not defined in the Plan. In order to strike out the claim at this preliminary stage, the Trustees must show that it is clear and obvious that the plaintiff has no claim apart from allegations that constitute medical grounds. If there are factual issues or significant questions of law which, if resolved in the plaintiff's favour would entitle him to some relief, the claim should not be struck.

[39] In my view, it is far from clear that the question of whether the plaintiff is disabled within the meaning of the Plan is a purely medical question. The application of both branches of the Plan's definition of disability may well raise other than purely medical issues. While the judgment about Mr. Braithwaite's medical condition may be a purely medical ground, the interpretation of the definition of disability in the Plan may well not be.

[40] The distinction between matters of medical judgment and questions of contractual interpretation is illustrated by the decision of the Supreme Court of Canada in **The Paul**

Revere Life Insurance Co. v. Sucharov, [1983] 2 S.C.R. 541. That case arose from an action on a policy of insurance which defined "total disability" as "completely unable to engage in his regular occupation", a definition similar to that in the Plan. The issue before the Supreme Court of Canada was whether the Courts below had applied the wrong legal test to distinguish total disability from partial disability. The medical evidence in the case was not disputed; the medical judgment about the plaintiff's condition was clear. However, there remained a significant legal issue as to the correct legal interpretation of the phrase "completely unable to engage in his regular occupation". That legal issue occupied three levels of court and gave rise to a division of view in both the Court of Appeal and the Supreme Court of Canada. This case seems to me to show that whether the plaintiff is disabled under the Plan is not purely a medical question. There was no dispute as to Sucharov's medical condition; the dispute concerned the proper interpretation of the contract. To draw the analogy to the present appeal, it is not clear and obvious that the question of Mr. Braithwaite's disability under the Plan is a medical ground only and therefore fully and finally resolved by the medical appeal system.

[41] It is helpful to give two examples of arguably non-medical issues that may arise in Mr. Braithwaite's action. In applying the first branch of the definition of disability in the Plan, there may be an issue concerning what the employee's "regular duties" include and what portion of them he must be unable to perform in order to fall within the definition. The Plan's definition of disability requires that the medical judgment about Mr. Braithwaite's condition be linked to a specific set of job duties. A final determination of the medical condition is not, therefore, a final determination of whether the plaintiff is disabled within the

meaning of the Plan.

[42] On the record before the Court, it appears that precisely such an issue may arise in this case. The record shows that the plaintiff was assigned modified duties during the period of time covered by the first branch of the definition, that he refused to perform these modified duties and that this refusal was one of the reasons for the termination of his benefits. Ms. Ryan, the coordinator of LTD benefits for the Plan, states in her affidavit that in July of 1996, Mr. Braithwaite was offered employment "...with his job responsibilities modified to accommodate..." his emotional difficulties and that this modified employment "...was approved as a rehabilitation employment program by the Plan Administrator and by the Trustees." She goes on to depose that at that time, "... it was the view of the Plan Administrator that Mr. Braithwaite was no longer disabled as defined in the LTD plan and... that he had refused to participate in a rehabilitation employment program approved by the Trustees." As noted, the definition of disability for the first 30 months and the 100 day elimination period requires that the employee be completely unable to perform the regular duties of his/her occupation. Regular duties are defined in the Plan as "...the duties that the employee was expected to perform immediately prior to the commencement of the elimination period." There is no reference to modified duties. Accordingly, before it could be shown that the plaintiff's claim that he is disabled under this branch of the definition is a purely medical matter, it would have to be shown that there is no triable issue concerning the precise duties to which the medical judgment ought to be applied. On the record we have, this is not clearly made out; in fact, a reasonable inference from the limited record before the Court is to the contrary.

[43] The same may be said with respect to the plaintiff's refusal to participate in a rehabilitation employment program approved by the Trustees, the other reason given for termination of Mr. Braithwaite's benefits. Under section 1 (l) of the Plan, "rehabilitation employment program" means a mandatory program as contained in Guidelines made pursuant to the Plan. There are no such Guidelines in the record and no evidence that they exist. Whether they exist and whether the plaintiff wrongly refused to participate in such a program are at least arguably not purely medical issues. For that matter, there appears to be a triable issue as to whether a failure to accept modified employment takes the employee out of the first branch of the definition of disability in the Plan which, as noted, refers only to the ability to perform regular duties, that is, the duties he was expected to perform prior to the elimination period. These seem to me to be at least arguably matters of contractual interpretation, not purely matters for medical judgment.

[44] Under the second branch of the definition, there are also issues which arguably are not purely medical ones. These include, for example, the question of the occupations for which the claimant may become fit through education, etc. and the rates of pay for them. The question for now is not whether these are or are not purely medical questions, but whether the Trustees have demonstrated that they clearly are on this interlocutory application. In my view, they have not done so.

[45] In summary, the Trustees have failed to demonstrate that there are no triable issues concerning whether the termination of benefits was on purely medical grounds or that Mr. Braithwaite's allegation that he is disabled within the meaning of the Plan is a purely

medical matter. Moreover, on the record before us, precisely what the medical appeal board, Dr. Reid, decided is a matter of speculation. All we know is that Mr. Braithwaite was told he could appeal on medical grounds only, that he did so, apparently without the assistance of counsel and that his appeal was denied without reasons. Assuming that Dr. Reid addressed only questions within his jurisdiction (i.e. medical grounds), it has not been shown that the resolution of the medical issues (whatever they were) makes it clear that the allegation that Mr. Braithwaite is disabled within the meaning of the Plan is unsustainable.

[46] The appellants argue that it should be presumed that Dr. Reid acted within the scope of his authority absent some specific allegation that he did not and absent a challenge to his decision by way of judicial review. The appropriateness of making this assumption will be considered in my discussion of *res judicata* and collateral attack. However, even if this assumption should be made (and I think that is far from clear), the question is not so much whether Dr. Reid acted within his jurisdiction, but what that jurisdiction is. In other words, what constitutes a medical ground within the meaning of the Plan is a key question in order to determine whether the plaintiff's case is properly before the Courts or may only be pursued through the medical appeal process. The record is not at all helpful in resolving this point. The question of what is a medical ground and how it relates to the definition of disability under the Plan are, in my opinion, triable issues.

[47] The appellants say that we should presume that what Dr. Reid decided was that the plaintiff was fit to work. Assuming that is so, it does not follow that the plaintiff's claim

should be dismissed on an application to strike the statement of claim. Before that result follows, the Court would have to be persuaded that "fitness to work" is a purely medical question, that Dr. Reid's determination of it is conclusive and that the medical judgment of "fitness to work" is determinative of the issue of disability under the Plan. The medical judgment of fitness for work is not dispositive unless linked to a specific set of job duties which constitute the "regular duties" of the claimant's occupation as set out in the first branch of the definition of disability. If the second branch of the definition is relevant, then the link must be between the medical condition of the claimant and occupations for which the claimant "is or may become fit through education, training, experience or rehabilitation" and which pay not less than 80% of the current rate of the pre-disability position. We do not know precisely what Dr. Reid decided. We do not know precisely what "a medical ground" is for the purpose of delineating the boundary between the issues entrusted to Dr. Reid and the issues left to the Courts. Assuming a medical ground means a determination of the claimant's medical condition, it is not clear that an accurate assessment of the plaintiff's medical condition fully disposes of the issue of whether he is disabled within the meaning of the Plan. The plaintiff specifically pleads that the proper definition was not applied. In my view, there are triable issues.

[48] It is argued that this Court in **Bacich et al. v. Holt** , [1998] N.S.J. No. 497 (December 21, 1998) decided that the question on a medical appeal under the Plan is whether the claimant is disabled within the meaning of the Plan. I disagree with this interpretation of **Holt.** In **Holt**, it was assumed by the parties, and thus by the Court, that

the issue before Dr. Reid in that case was whether Ms. Holt was disabled within the meaning of the Plan. It was not argued that aspects of the definition of "disabled" are not medical grounds and there is no decision on this point in **Holt**.

[49] We were not referred to authorities that are helpful in drawing the distinction between medical grounds and matters of contractual interpretation. The most closely analogous case that I have found is **Regina Professional Fire Fighters Assn., Local No. 181 v. Regina (City)** (1990), 83 Sask. R. 260 (C.A.). In that case, the plaintiff sued his former employer for payment of disability benefits. He had claimed benefits and the claim had been dealt with by a medical tribunal. The medical tribunal had the authority to resolve disputes where there was doubt about the validity of the claim "on medical grounds". The tribunal determined that the plaintiff's disability was caused in part by smoking, in part by work-related environmental conditions and in part by a pre-existing medical condition. The tribunal concluded:

> Though in time he probably has had more exposure to cigarette smoke and carbon monoxide from cigarettes than to noxious gases from his occupation, the degree and type of exposure during his work clearly played a role. We found we were not able to apportion anymore than equal blame to his smoking and his occupation, and felt therefore that his present disability was at least in part, related to his work, and that Clause III of the Union Contract with the City, particularly SubSection D, would not apply.
>
> We felt that the city was liable, at least in a 50% fashion to his disability which we felt was close to 100%.

[50] The plaintiff argued unsuccessfully at trial that the trial judge should conclude that this decision of the medical tribunal was binding and that the City was therefore liable to make disability payments. The defendant City argued that the tribunal's decision was not

binding on the court because the tribunal's finding of concurrent causes contributing to the plaintiff's disability involved a question of interpretation of the Collective Agreement which was beyond the jurisdiction of the medical tribunal. The City's argument prevailed at trial and on appeal. Gerwing, J.A., for the majority in the Court of Appeal, concluded that the medical tribunal may determine if the accident or disability was "obviously not related" to the plaintiff's work, but that the legal meaning of the contract in the context of a finding of 50/50 liability is a legal question of contractual interpretation which is not within the exclusive jurisdiction of the medical tribunal. This conclusion was reached on appeal from a finding made after trial on an agreed statement of facts. It was not addressed, as the Trustees have attempted to do here, on an application to strike out the statement of claim.

[51] In the case of Mr. Braithwaite, his statement of claim arguably raises issues of interpretation of the Plan that are not clearly within the jurisdiction of the medical appeal process. It follows that, as in **Regina Firefighters,** such questions of interpretation are not settled by the medical tribunal's decision. Therefore, there are issues pleaded in the statement of claim that should be tried.

2. *Res judicata*:

[52] The appellants submit that the plaintiff's disability claim is *res judicata*, having been decided by the medical appeal process. However, not a single case relating to *res judicata* is cited in support of this submission.

[53] The application of *res judicata* in cases such as this raises significant and difficult legal issues. There is voluminous case law and the applicable legal principles are not clearly settled. It follows that these questions would better be determined at trial. Without attempting to be definitive or comprehensive, it is helpful to briefly set out some of the issues that would have to be considered to give effect to the submission that the claim is *res judicata*.

[54] The basic rules relating to *res judicata* are stated in G. Spencer Bower and A. K. Turner, ***The Doctrine of Res Judicata*** (2d, 1969) at 18:

> Any party who is desirous of setting up *res judicata* by way of estoppel, whether he is relying on such *res judicata* as a bar to his opponent's claim, or as the foundation of his own, and who has taken the preliminary steps required in order to qualify him for that purpose, must establish all the constituent elements of an estoppel of this description, as already indicated in the general proposition enunciated at the commencement of this chapter. That is to say, the burden is on him of establishing (except as to any of them which may be expressly or impliedly admitted) each and every of the following:
>
> (i) that the alleged judicial decision was what in law is deemed such;
>
> (ii) that the particular judicial decision relied upon was in fact pronounced, as alleged:
>
> (iii) that the judicial tribunal pronouncing the decision had competent jurisdiction in that behalf;
>
> (iv) that the judicial decision was final;
>
> (v) that the judicial decision was, or involved, a determination of the same question as that sought to be controverted in the litigation in which the estoppel is raised;
>
> (vi) that the parties to the judicial decision, or their privies, were the same persons as the parties to the proceeding in which the estoppel is raised, or their privies, or that the decision was conclusive *in rem*. (emphasis added)

[55] The onus of proving the constituent elements of *res judicata* is on the party alleging its application, in this case the Trustees. The jurisdiction of the tribunal whose decision is relied on is not presumed but must be established. So too must the element that the same question as that raised in the subsequent proceeding was determined in the previous one. Therefore, for the purposes of applying *res judicata*, the Trustees' argument that it must be

presumed that Dr. Reid acted within his jurisdiction should be rejected; the burden of proving that Dr. Reid acted within his jurisdiction is on them. Moreover, there being no evidence of what Dr. Reid actually decided, the Trustees have not discharged their burden of showing that he decided the same question as is raised in the plaintiff's action.

[56] There are also special considerations that come into play when a decision of a tribunal rather than a Court is relied on to support a claim of *res judicata*. This is especially true where, as here, the authority to deal with disputes is divided between a tribunal and the Court. For example, in **Minott v**. **O'Shanter Development Co.** (1999), 168 D.L.R. (4th) 270 (Ont. C.A.), application for leave to appeal filed March 8, 1999; [1999] S.C.C.A. No. 120, the Court held that there is a discretion as to whether *res judicata* will be applied with respect to the determinations of administrative tribunals. As Laskin, J.A. said at p. 289: "Issue estoppel is a common law rule and therefore the courts must consider the appropriateness of applying it to the findings of a tribunal ...". Fundamental to the exercise of this discretion is whether the application of *res judicata* in the circumstances would be unfair or work an injustice. That considered, it is far from obvious to me that *res judicata* should be applied here. Moreover, the discretion to apply or not to apply *res judicata* should be exercised in light of all relevant circumstances, a task not properly undertaken on the limited factual record before the Chambers judge or this Court on appeal.

[57] In short, there is a triable issue as to whether a determination such as that made by Dr. Reid may be used as the basis for a plea of *res judicata*, there is a triable issue as to whether the discretion of the Court should be exercised in favour of the plaintiff even if it

may be so used and the appellants have failed to show that Dr. Reid acted within his jurisdiction or that the issue decided by Dr. Reid is the same issue as that pleaded in the Statement of Claim. Accordingly, the action should not be dismissed summarily on the basis of *res judicata*. The Chambers judge, in my view, made no reviewable error in refusing to strike the statement of claim on this basis.

3. Collateral Attack:

[58] The appellants argue that to allow this action to proceed would constitute a collateral attack on Dr. Reid's decision on the appeal. The question of whether this is so seems to me to be sufficiently unclear that the action should not be summarily dismissed on this basis. We were not referred to a single case dealing with the collateral attack doctrine. My understanding is that whether to allow a proceeding to continue which may have the effect of challenging collaterally the validity of the decision of an administrative tribunal is primarily a matter of judicial discretion: see David Mullan, *"Administrative Law*" in **Canadian Encyclopaedic Digest** (3d), vol. 1, title 3, para. 603. In this case, there is now no dispute that medical issues are dealt with under the medical appeal process provided for in the Plan but that other issues go to the courts. Given that there may be issues other than medical issues involved in this action and that authority to deal with the issues is divided between the medical appeal process and the courts, I do not think it obvious that this discretion should be exercised at this preliminary stage to preclude Mr. Braithwaite's action from proceeding. The exercise of this discretion should, in my opinion, be left to the trial judge or at least to a judge with a full view of the relevant facts and circumstances. This is

particularly so where the plaintiff's action is in the same Court that would have authority to deal with Dr. Reid's decision by way of judicial review and where no judicial review application was made.

[59] The collateral attack doctrine is concerned with ensuring finality, preserving the integrity of decision-making processes and requiring parties to pursue the most appropriate avenue of challenge. In this case, the only other avenue of challenge to Dr. Reid's decision is by way of judicial review. There is no alternative, more comprehensive review available before an expert tribunal as there was, for example, in **Danyluk v. Ainsworth Technologies Inc.** (1998), 167 D.L.R. (4th) 385 (Ont C.A.), application for leave to appeal filed February 1, 1999; [1999] S.C.C.A. No. 47. Permitting collateral attack in this case, where the challenge is in the same Court as is entitled to consider the matter by way of judicial review does not allow Mr. Braithwaite to by-pass a specialized and comprehensive review process. Given that no application for judicial review was taken, the present action does not create any duplication of reviews. Moreover, because authority to deal with disputes under the Plan is divided between the medical appeal process and action in the courts, it may be appropriate where issues of both kinds are raised, to proceed by action so that the questions of jurisdiction of the medical appeal process and the issues properly dealt with in Court may be adjudicated together.

[60] I am far from persuaded that this action involves a collateral attack. Even if it did, I do not think it appropriate to strike out the action at this preliminary stage on that basis

because a clear case for doing so has not been made out by the Trustees.

[61] In summary, this case raises difficult issues of the relationship between medical grounds addressed through the medical appeals process provided for in the Plan and other disputes arising under the Plan which are to be pursued in the courts. These issues turn on factual questions which are not adequately addressed on an interlocutory application of this kind and on difficult, and in some cases, novel legal questions. These are not the kinds of questions which should be resolved against Mr Braithwaite on an application to strike out his statement of claim. I see no error in principle in, nor any injustice caused by, the Chambers judge's decision refusing to strike the statement of claim. I emphasize that I have not attempted to rule definitively on what constitutes a medical ground, the application of *res judicata* or any of the other issues raised other than to say they are triable issues. They may be raised by way of defence and dealt with accordingly.

[62] For these reasons, I would grant leave to appeal but dismiss the appeal with costs fixed at $1,500.00 plus disbursements and payable forthwith.

Cromwell, J.A.

Concurred in:

Roscoe, J.A.