Automobile Injury Compensation Appeal Commission

IN THE MATTER OF an appeal by [the Appellant]
AICAC File No.: AC-98-76

PANEL:	**Mr. J. F. Reeh Taylor, Q.C., Chairman** **Mr. Charles T. Birt, Q.C.** **Mrs. Lila Goodspeed**
APPEARANCES:	**Manitoba Public Insurance Corporation ('MPIC') represented by Ms Joan McKelvey;** **the Appellant, [text deleted], was represented by [Appellant's representative]**
HEARING DATE:	**September 14th, 1999**
ISSUE(S):	**1. Whether Appellant's physical conditions caused by motor vehicle accident;** **2. Whether Appellant was thereby prevented from return to work and, therefore, entitled to continued income replacement indemnity ('IRI').**
RELEVANT SECTIONS:	**Section 81(1) of the MPIC Act**

AICAC NOTE: THIS DECISION HAS BEEN EDITED TO PROTECT THE APPELLANT'S PRIVACY AND TO KEEP PERSONAL INFORMATION CONFIDENTIAL. REFERENCES TO THE APPELLANT'S PERSONAL HEALTH INFORMATION AND OTHER PERSONAL IDENTIFYING INFORMATION HAVE BEEN REMOVED.

REASONS FOR DECISION

On January 10th, 1996, at about 7:20 A.M., the [text deleted] being driven by the Appellant was struck on the right side by a [text deleted] that had run through a red light. The Appellant's [text deleted] year old daughter, a passenger in the right front seat, was uninjured, but [the Appellant]

sustained some injuries to her low back, at the scapulo-thoracic area and at the upper left trapezius. The vehicle was written off.

[The Appellant], now aged [text deleted], came to Canada in [text deleted]. She testified that she has worked ever since coming to Canada. Initially, she worked in a factory; she and her husband then ran a [text deleted] store for some twelve years but lost that business due to financial difficulties; they started the [text deleted], a café, but lost that for similar reasons; she then worked for [text deleted] for some eighteen months, and then for [text deleted] from August 22nd, 1995 until her motor vehicle accident ('MVA') on January 10th, 1996. Her time in the work place had been interrupted by approximately two years of absences resulting from MVAs in 1987 and 1991, plus a lengthy absence due to a Workers' Compensation claim in 1994. She testified that she had recovered fully from those earlier injuries or, at least, was symptom-free, by the time of her January, 1996 MVA.

At the time of her 1996 accident [the Appellant], who is left-hand dominant, was employed by [text deleted] as a sewing machine operator, making seat covers. Her work required her to be seated most of the time. She would swivel her chair to the left in order to pick up material, and would then work at the sewing machine, leaning forward slightly, moving her hands, arms and shoulders in a variety of directions in order to feed the material through the machine. Her hours of work were from 7:30 A.M. to 4:00 P.M., with a one-half hour break for lunch and a ten minute break each morning and each afternoon.

As will appear from these Reasons, the issues before us may be summarized this way:

(i) was [the Appellant] suffering, at all material times, from shoulder girdle myofascial pain?

(ii) was [the Appellant's] shoulder suffering, at all material times, from adhesive capsulitis, capsular inflammation or tendonitis, secondary to myofascial pain of the shoulder girdle?

(iii) was either or both of the foregoing conditions, if present, caused by her motor vehicle accident of January 10th, 1996? and

(iv) if the answer to question (iii) is affirmative, was the Appellant thereby prevented from returning to her previous, full-time employment?

Following her accident, [the Appellant] was provided with IRI, as well as multi-disciplinary rehabilitative therapies by successive caregivers funded by MPIC. On October 25th, 1996, [the Appellant's] Case Manager at MPIC wrote to her to tell her that recent assessment findings had failed to identify any physical impediment preventing her from returning to her pre-accident hours of work at the level she had enjoyed prior to her accident. In consequence, she was told, her entitlement to IRI benefits had reached a conclusion as of October 18th, 1996, in the absence of any medical basis for further payment. [The Appellant] was advised by her Case Manager to "contact your employer to place you on payroll as an active employee effective immediately". She applied for an internal review at MPIC from that decision on May 12th, 1997 and, on April 30th, 1998, the Internal Review Officer upheld the decision of the Case Manager. (The unusual delay in the rendering of that decision is satisfactorily explained in the preamble to the decision itself.) A Notice of Appeal from the internal review decision was filed with this Commission on June 1st, 1998, since which date we have received a large quantity of additional medical evidence and this, combined with the need to find dates upon which all of the medical witnesses could be available, materially delayed the hearing of [the Appellant's] appeal.

Evidence of [the Appellant]

After giving us the background information briefly described above, [the Appellant] testified that she had returned to work on the day following her accident but had been unable to continue. Her family physician, [text deleted], had referred her to [text deleted] Physiotherapy Clinic, where she had initially received massage treatments for her shoulders and back; after a couple of months she started exercising on a stationary bicycle. (Report from [physiotherapy clinic] also indicates the use of reciprocal pulleys.)

Meanwhile, her Case Manager at MPIC had referred her to [text deleted], Vocational Rehabilitation Consultants, where [text deleted] assumed direction of her rehabilitation. [Appellant's rehabilitation director] sent her to the [rehab clinic] where she was assessed by [Appellant's physiotherapist #1] and started a rehabilitation program. The occupational therapist who had been working with her, [text deleted], attended at the Appellant's workplace at [text deleted] with her, and was able to arrange for a number of adjustments to various aspects of the work site, including the 'free arm' of the work table and its distance from the position of the needle on the sewing machine, the height of her chair, the foot pedal placement, the knee pad and the working posture of [the Appellant] herself. [The Appellant] had also been given a lumbar belt support.

She was then introduced to a graduated return-to-work program, starting at two hours per day with the intent of working gradually back to her full shift. During a normal working day, [the

Appellant] testified, she could work through three to four bundles of materials daily, producing 400 to 500 finished pieces; after her accident she could barely finish one bundle.

Concurrently with her graduated return to work ('GRTW') [the Appellant] testified that she was continuing to attend at [rehab clinic] where she did stretching exercises, and at [text deleted] Pool where she did her aquacises, while continuing to use a stationary bicycle at her home.

Near the end of October [the Appellant] had received a letter from her Case Manager at MPIC, [text deleted], to tell her that

> Following your completion of the (rehabilitation program at [rehab clinic]) the recent assessment findings failed to identify any physical impediment preventing you from returning to your pre-accident hours of work, at the level you enjoyed prior to the accident. Accordingly, your entitlement for income replacement benefits has reached a conclusion as of October 18th, 1996, in the absence of any medical basis for further payment.

[Appellant's MPIC case manager's] letter recommended that [the Appellant] contact her employer in order to be placed back on the payroll as an active employee immediately. She did not, in fact, return to work.

[Appellant's doctor] then referred [the Appellant] to the [text deleted], where she was seen on March 13th, 1997, by [Appellant's rehab specialist #1]. [Appellant's rehab specialist #1] referred her to [text deleted], a clinical nurse specialist in rehabilitation, for counseling in pain management and coaching in home exercises techniques. [Appellant's rehab specialist #1] had given her injections a couple of times; these had helped and the pain had gone away for about one and a half days but had then returned.

[The Appellant] told us that she had tried to work at a factory for a couple of weeks in January of this year but had been unable to keep it up. Her husband and her daughter had done most of the housework during 1996 and 1997.

[The Appellant] emphasized that her earlier claims against MPIC had related to injuries to the right side of her body, whereas her most recent accident had affected her left side and, in particular, her left shoulder. She had now obtained a job doing light cleaning duties from 7 A.M. until 3 P.M., at which point she walks across to help her husband who is working nearby. They both go home at about 4:30 P.M.

While attempting her GRTW, she would do her exercises in a cubicle in the washroom at work, stopping whenever she felt pain. That, of itself, gave rise to further problems since, although she was being paid IRI during her GRTW program, her co-workers were unaware of that and believed that she was slacking by taking bathroom breaks that were too numerous and too long. During much of the relevant time, [the Appellant] was also suffering from certain gynaecological problems unrelated to her accident.

[The Appellant] added that she was still doing her home exercises at the time of the hearing of her appeal; [Appellant's doctor] is the only physician whom she now sees.

Evidence of [Appellant's supervisor]

[Text deleted] was [the Appellant's] supervisor at [text deleted]. The plant made seat covers, a set being one seat and one back; each worker was required to produce a minimum of 150 sets per

day. The basic hourly rate of pay could be enhanced by greater production. She described [the Appellant's] job as physically demanding, with a lot of movement of the body in every way; "You need to be fit", she said. [The Appellant] had been an excellent worker. She had been happy to let [the Appellant] come in a GRTW program and to modify her work station. When [the Appellant] indicated she could not keep going, [Appellant's supervisor] had tried to find her lighter work to do but there was not much work of that type. [The Appellant] had called [Appellant's supervisor] in December 1998 and, again, in early 1999, seeking full-time employment at a lighter level, but there was none available.

The Evidence of [Appellant's doctor]

[Appellant's doctor] was apparently unavailable to give oral testimony at the hearing of this appeal. We were obliged to rely upon his written reports which may be summarized this way (dates shown are the dates [Appellant's doctor's] examinations of [the Appellant]):

January 10th, 1996

[Appellant's doctor] finds low back pain, spasm of paravertebral muscles, radiation of pain to anterior abdominal wall; acute anxiety. He diagnoses strain injury to lumbar back and prescribes analgesics and anti-inflammatory medication. He advises Appellant against bending, lifting, carrying, repetitive back movements and prolonged standing up. She cannot return to work. He refers her to [text deleted] Physiotherapy.

February 15th, 1996

He reports continuance of considerable pain at lumbosacral spine, also at the scapulo-thoracic level. He noted increased tone (by which we take him to mean, in this context, tension) at the upper part of the left trapezius and of the erector spine at the lumbar level. [The Appellant] was still incapable of resuming her main occupation and should do no lifting, bending, carrying or repetitive use of her left upper extremity. In a further report arising from the same examination, [Appellant's doctor] describes a 60% reduction in range of movement in the lumbosacral region of [the Appellant], an inability to lift with her left arm; movements of abduction and frontal flexion restricted by 40%, and the Appellant was capable of rotation of the left arm of only 10 to 15%. Pain in the thoracic region was apparent upon deep breathing and upon rotation of the trunk. He noted increased tone of the paravertebral muscles, lumbar segment, left trapezius, rhomboids and levator scapula. He recommended physiotherapy three times per week for four weeks and offered a tentative date of return to work of March 11th, 1996. ([Appellant's doctor] emphasized the word 'tentative'.)

March 27th, 1996

[Appellant's doctor] reports that the main incapacitating problems of [the Appellant] were her continuing pain at the cervical and left scapula region, together with low back pain. [The Appellant] was receiving physiotherapy for both problems; progress was slow.

[The Appellant] was experiencing continuing pain of the left shoulder region, with increased tenderness of the trapezius, rhomboids and levator scapula on the same side. The increased pain in the left upper extremity was a cause of disability for [the Appellant] who was required to perform repetitive movements with her left upper extremity while at work. Recent X-rays of the

left shoulder had indicated minor degenerative changes at the acromioclavicular joint, thoracic spine X-rays had disclosed some osteophytes at the middle and lower thoracic regions, as well as large osteophytes at T9 and T10, with the possibility of cervical-thoracic dysfunction. X-rays of the lower back showed no abnormality, but physical examination indicated tenderness of the erector spine on the left side and over the quadratus lumborum and gluteus maximus.

[Appellant's doctor] had referred [the Appellant] to [Appellant's orthopaedic specialist] for an orthopaedic opinion. [Appellant's doctor] did not feel that the Appellant was ready to assume full-time employment although she might be capable of doing three or four hours shift work.

March 24th, 1999

[The Appellant's] problem continued to be the pain in her left shoulder and on the left lateral side of her neck, with periodic exacerbations from no apparent cause. Her neck and left shoulder girdle movements were limited by the pain; she was unable to perform repetitive movements, to lift and hold objects of more than two pounds. Abduction and frontal elevation movements were limited to 85-95 degrees only. [Appellant's doctor] re-emphasized that [the Appellant] is left-hand dominant. Analgesics offered no benefit and the only relief was from infiltration of trigger points. The Appellant had made an attempt to return to work in February 1999 but could only do so for two weeks due to increased pain. [Appellant's doctor] concurred with a recommendation of [Appellant's rehab specialist #2] (q.v.) that [the Appellant] seek a different type of work.

Evidence of [Appellant's orthopaedic specialist]

[The Appellant] was seen by [Appellant's orthopaedic specialist] on April 11th, 1996. In his report of June 13th, 1996 to MPIC, [Appellant's orthopaedic specialist] says that "The patient herself indicated that she had no body impact with the steering column, dash or door. ([the Appellant's] evidence to this Commission was that she had hit the left side of her head on the window or door.) Immediately following the accident, she had started to have pain at the base of the neck and left parascapular area; that pain had started to settle down towards the lower part of her back. Although [the Appellant] had had no headaches immediately following the accident, she had started to develop them about two weeks later. During her visit to [Appellant's orthopaedic specialist], [the Appellant's] main concern had been pain at her lower back radiating to the left lateral thigh, and pain at the base of the neck and shoulder which had subsided almost completely.

[Appellant's orthopaedic specialist] described the Appellant as having walked without any visible limp or distress with normal heel/toe gait. She could sit, leaning on both elbows in the chair. She had full rotation of the upper and lower torso. Neck motion was not restricted and no appreciable trigger point pain was noted at the neck region. Internal and external rotation of the left shoulder were 'minorly restricted, not beyond 15 degrees with pain on stress'. [Appellant's orthopaedic specialist] noted no wasting of the shoulder girdle muscle but some minor tenderness of the left levator scapula. Neurologically, said [Appellant's orthopaedic specialist], no abnormalities were noted; reflexes were present and equal; no gross sensory nor motor change was noted.

From X-rays dated March 27th, 1996 brought to him by [the Appellant] from [Appellant's doctor's] office, [Appellant's orthopaedic specialist] noted (in addition to certain other degenerative skeletal changes) "Early degenerative change at the AC (i.e. *acromioclavicular*) joint mainly." He concluded that

> The patient was suffering from lumbosacral sprain superimposed on pre-existing disk degenerative disease involving the thoracolumbar area…….the patient also has osteoarthritic change at the left AC joint. Obviously this present motor vehicle accident caused some flare-up of this area in the line of soft tissue injury or sprain. During her visit to my office, on clinical grounds, it appears that the patient's effects of the injury have subsided reasonably well. The patient was advised to be treated symptomatically by [Appellant's doctor]. Considering the persistence of pain, the patient has undergone bone scan on April 22nd, 1996 which indicated mild degenerative change at the thoracolumbar region mainly. No acute process.

The Evidence of [Appellant's rehab specialist #1]

[Appellant's rehab specialist #1] was, at relevant times, [text deleted] of the Section of Physical Medicine and Rehabilitation at [text deleted].

March 20th, 1997

[Appellant's rehab specialist #1's] initial report to [Appellant's doctor], resulting from his examination of [the Appellant] on March 13th, 1997, describes [the Appellant] as a "[text deleted]-year-old furniture polisher" who had been unemployed since a motor vehicle accident in January 1996. She had described pain in the left shoulder girdle, with discomfort extending into the neck and down into the left anterior chest, and into the left arm and hand. She also complained of discomfort in the left low lumbar area and upper buttock, but without referral of

pain into the abdomen or groin. There was pain down the side of the left leg as far as the knee. She was sleeping poorly at night.

[Appellant's rehab specialist #1] noted a clearly asymmetrical gait pattern with discomfort on the left leg weight-bearing; left shoulder had limitation of active range of motion with only 110 degrees of flexion and 120 degrees of abduction. There was some loss of internal rotation compared to the right side with tenderness over the biceps tendon. Cervical mobility was not markedly reduced but there was pain in the outer range of motion on rotation in lateral flexion in the left trapezius muscle. [Appellant's rehab specialist #1] could not discern any evidence of spinal root or thoracic outlet compromise, and found no neurological deficit in the shoulder girdle or upper limbs.

Soft tissue examination showed myofascial taut bands in the upper trapezius, levator scapulae, infraspinatus, rhomboids and pectoralis major muscles on the left side. The left quadratus lumborum and thoracic iliocostalis muscles showed similar trigger points on the left side; there was pain in the left sciatic notch, with discomfort aggravated by external rotation of the hip, indicating a piriformis syndrome.

X-rays of the left shoulder showed no significant bone joint or soft tissue abnormality.

[Appellant's rehab specialist #1] diagnosed a persisting chronic myofascial pain syndrome of the left shoulder girdle and low back which was now associated with a bicipital tendonitis in the shoulder itself. He felt that [the Appellant] also had associated sleep dysfunction.

[Appellant's rehab specialist #1] prescribed 10 - 20 mg of Cyclobenzaprine (a muscle relaxant) to be taken at bedtime. He referred [the Appellant] to [text deleted], clinical nurse specialist in rehabilitation, for general counseling and the introduction of appropriate stretching exercises at home. He felt that if [the Appellant] did not improve within two to three weeks with a home program, it would be time to commence a course of outpatient physiotherapy.

Concurrently with [Appellant's rehab specialist #1's] first report, a letter signed jointly by [Appellant's rehab specialist #1] and [Appellant's clinical nurse specialist in rehabilitation] and addressed to [Appellant's MPIC case manager] outlined the kinds of education counseling that were proposed for [the Appellant] and sought authorization to conduct four hours of that counseling at the expense of MPIC. That authorization does not appear ever to have been given. (On May 14th, 1997, MPIC received an application for an internal review of [Appellant's MPIC case manager's] decision to discontinue benefits.)

May 28th, 1997

[Appellant's rehab specialist #1's] report to [Appellant's doctor] notes a deterioration in active abduction of the left shoulder from 120 degrees to 85 degrees, increased tenderness over the bicipital tendon and continuing weakness of the scapular muscles. [Appellant's rehab specialist #1] concluded that the diagnostic picture remained the same, with "a chronic post-traumatic myofascial pain syndrome to which had been added a secondary capsulitis of the left shoulder". This was not going to improve, said [Appellant's rehab specialist #1], without further treatment and he had therefore arranged physiotherapy to try to mobilize and strengthen the left shoulder and to address the associated myofascial discomfort. He was considering injections of Corticosteroid to the shoulder or of Xylocaine to trigger points.

July 15th, 1997

In a letter of this date to counsel for [the Appellant], [Appellant's rehab specialist #1] expresses the view that the course of therapy provided by [the Appellant's] former caregivers had caused improvement but had not caused adequate remission of symptoms; her regional myofascial pain syndrome initiated by the motor vehicle accident was continuing and had now become complicated by the emergence of secondary tendonitis in the left shoulder. Movement range in that shoulder had deteriorated to the point of only 80 degrees of abduction and 100 degrees of forward flexion, with internal rotation only bringing the thumb to the level of the buttock. [Appellant's rehab specialist #1] repeats his earlier comments respecting tenderness over the bicipital tendon and weakness of the stabilizer muscles to the shoulder, particularly in external rotation.

[Appellant's rehab specialist #1's] letter concludes

> She continues to show myofascial taut band activity in the muscles described in previous correspondence and requires to get back to therapy in order to mobilize the shoulder and bring the myofascial pain under better control with such procedures as exercise therapy and local infiltration with Xylocaine into the painful trigger points.
>
> Capsular inflammation of a shoulder joint is a common secondary complication of shoulder girdle myofascial pain. Both the myofascial pain and her secondary condition need active physiotherapy to get this patient back to employability.

November 4th, 1997

[Appellant's rehab specialist #1's] report to [Appellant's doctor] of this date reflects increasing problems by [the Appellant] with "pain in her left frozen shoulder with flexion of the joint limited to 80 degrees and abduction to 50 degrees". He had infiltrated the joint with Triamcinolone, which had apparently lessened [the Appellant's] pain and had increased her

range of movement to 90 degrees in flexion and 90 degrees in abduction. He felt that it might be necessary to consider referring [the Appellant] to the Department of clinical psychology.

There followed an exchange of opinions between [Appellant's rehab specialist #1] and [text deleted], Medical Director of MPIC's Claims Services Department, from which it is apparent that the views of these two experts diverge markedly on the subject of myofascial trigger points and on the likelihood of a cause and effect relationship between [the Appellant's] motor vehicle accident and the problems she was experiencing with her left shoulder. Each makes reference to certain scientific literature in support of his opinions. While they obviously disagree upon the reliability of certain criteria in the diagnosis of myofascial pain syndrome, they appear to be in agreement on the point that the etiology of myofascial pain syndrome is still one of much professional speculation but little, if any, professional accord.

[Appellant's rehab specialist #1's] Oral Testimony

At the hearing of [the Appellant's] appeal, [Appellant's rehab specialist #1] expanded upon his earlier, written opinions. When he had first examined her, he said, she was unable to perform the repetitive actions demanded by her workplace - not, at least, without pain. [Appellant's rehab specialist #1] expressed the opinion that myofascial pain results from an overloading of the skeletal muscle; one of the primary diagnostic factors is the presence of taut bands, which [Appellant's rehab specialist #1] equates with so-called 'trigger points'.

He had referred [the Appellant] to [Appellant's clinical nurse specialist in rehabilitation] because he felt the need for immediate reinforcement of [the Appellant's] home exercise program, he did

not know how soon he could get the Appellant in to physiotherapy and she needed someone with more time to spare than [Appellant's rehab specialist #1] had in order to counsel her about pain management.

Despite that, [the Appellant] had deteriorated from March 20th to June 5th, 1997. The stretching exercises that he and [Appellant's clinical nurse specialist in rehabilitation] worked on were addressing the myofascial pain, but not the tendonitis for which [the Appellant] needed physiotherapy. She needed physiotherapy that did not push her too hard. He felt that the strengthening program that had been part of [the Appellant's] earlier care was undermining the progress of her tendonitis. He felt, in hindsight, that there had been a drive to get the patient back to work, but it had failed. She had complained of a number of things but no one appeared to have been listening.

The emergence of tendonitis had resulted from [the Appellant's] need to use a painful limb or joint. She had a chronically painful shoulder and its constant use created the tendonitis - "That, at least, is probable, although I cannot be certain because there's no mention of it in 1996". He felt that [the Appellant] had needed almost entirely passive modalities of treatment, since active treatments would, in the early stages at least, have been contra-indicated. He acknowledged that, in his letter of July 15th, 1997, he had referred to [the Appellant's] need for "active physiotherapy" but now said that was in error.

[Appellant's rehab specialist #1] agreed that there is controversy about the causes, pathology and changes that take place in the course of myofascial pain; what is not controversial, he said, is its diagnosis.

[Appellant's rehab specialist #1] points to [Appellant's occupational therapist's] report of May 28th and [Appellant's physiotherapist #1's] report of June 5th, 1996, both of which indicated a low work tolerance by [the Appellant] and the latter's apparent belief that she was being asked by her caregivers to do too much. He felt that there ought to have been more involvement by [the Appellant's] family physician, [text deleted], (although that concern, it must be said, is not borne out by the clear evidence on the file that [Appellant's doctor] was being 'kept in the loop' both by correspondence and by consultation on a regular basis).

[Appellant's rehab specialist #1] testified that there may well be a latent period - perhaps a few hours or a couple of days - between a traumatic incident and the emergence of myofascial pain syndrome. "If you have a delay of a couple of weeks or more, you have to start questioning things." The Commission notes that the only two references to myofascial pain prior to [Appellant's rehab specialist #1's] report of March 20th, 1997, were found in [Appellant's physiotherapist #1's] letter of June 5th, 1996 and [Appellant's occupational therapist's] report of July 15th, 1996, some five and six months post-accident respectively.

[Appellant's rehab specialist #1] further testified that myofascial pain syndrome is, by definition, a treatable condition. The attending practitioner will treat sleep dysfunction, will apply heat, prescribe stretching exercises and, frequently, injections of Xylocaine to the affected areas. He agreed that the treatments that he and [Appellant's clinical nurse specialist in rehabilitation] had provided to [the Appellant] were much the same as had previously been given, save only for sleep medication. He had seen no chronic pain behaviour exhibited by [the Appellant], whose

responses and overt body language had been quite appropriate. Hers was not so much a case centered on joint range of motion but, rather, was simply that of a patient who could not cope.

[Appellant's rehab specialist #1] agreed that many members of the general public have trigger points, particularly in the trapezius and the quadratus lumborum areas. [The Appellant's] problems could have originated from her repetitive movement at work, but they did not seem to have appeared until after her motor vehicle accident. In the normal course, symptoms of the kind that she was exhibiting were more likely to be caused by constant, repetitive movement than by one, single event. He did believe that her sleep disorder was related to her motor vehicle accident.

[Appellant's rehab specialist #1] testified that myofascial pain syndrome does not necessarily remove the patient from the workplace. While the symptoms can reoccur, that did not mean that the patient suffered from a disability.

He had infiltrated [the Appellant's] shoulder joint once only and might have seen her once or twice in physiotherapy after September/October of 1997.

As time passed, [the Appellant] had developed adhesive capsulitis, often referred to as a 'frozen shoulder'. This results from an initial tendonitis, an inflammation of part of the shoulder's capsular structure; the pain resulting from that inflammation causes the patient to protect that shoulder by not using it and the lack of use, in turn, produces the frozen shoulder.

[Appellant's rehab specialist #1] was of the view that, on a balance of probabilities, [the Appellant's] condition could be corrected by the proper application of physiotherapy; that pending those corrective measures [the Appellant] was not able to return to her former employment, and that her condition had been created in large measure by her motor vehicle accident of January 10th, 1996.

Evidence of [Appellant's physiotherapist #1]

April 18th, 1996

[Appellant's physiotherapist #1] has a Masters degree in physiotherapy [text deleted]. [Appellant's rehabilitation director] had referred [the Appellant] to [Appellant's physiotherapist #1], firstly to review a report from [physiotherapy clinic] and, secondly, to examine [the Appellant] and provide recommendations.

[Appellant's physiotherapist #1] describes [the Appellant's] subjective complaints as left upper shoulder to elbow pain, pain across the low back and "now down the anterior and lateral portion of her left leg which started two to three days ago". [The Appellant] was able to drive a car but only for limited periods. Although left-hand dominant, her average grip strength was 70 pounds on the right and 30 pounds on the left, limited by weakness and some pain at the medial aspect of her left elbow. She had normal reflexes on the right and a mild decrease in the triceps reflex on the left. Her myotomes were Grade 5/5 and pain free, "except for left shoulder abduction which is Grade 4 and limited by weakness, left external rotation is limited by pain at the elbow, and her left lumbricalis and hand intrinsic muscles are Grade 4/5". [Appellant's physiotherapist #1] described [the Appellant's] neck range of motion as full in forward flexion and limited by 50% in right flexion with stretching of the left neck muscles. This, said [Appellant's physiotherapist

#1], was due to shortening and tightness of the muscle across the top of the left shoulder and neck. Leg length showed an apparent shortening of one-half centimetre on the left side.

[Appellant's physiotherapist #1] noted that [the Appellant] had been given two to three pool therapy sessions and two to three spray-and-stretch sessions to assess her response to the adaptive shortening and the irritability of the trigger points. In consequence, [Appellant's physiotherapist #1] reported, [the Appellant] had increased neck and back range of motion, decreased pain and decreased referral zones from the trigger points. She was also given a trial of a temporary heel lift in her left shoe which decreased the pain immediately upon walking and decreased the limp of the gait abnormalities significantly.

([Appellant's physiotherapist #1's] report also covers a number of aspects of the problems [the Appellant] was then encountering in her low back and lower extremities, but these have no direct bearing upon the matters now under appeal which relate, essentially, to [the Appellant's] left shoulder area.)

[Appellant's physiotherapist #1] recommended a four to six week integrated physiotherapy and occupational therapy program "with return to work as soon as possible in a graduated fashion". She added that [the Appellant] required further education regarding self-management of her muscle pain and increased function. She recommended educational sessions on one-on-one basis with [Appellant's occupational therapist], due to English being [the Appellant's] second language. [Appellant's physiotherapist #1] also recommended that the occupational therapist attend at [the Appellant's] work place to assess her ergonomics and work posture.

June 5th, 1996

[Appellant's physiotherapist #1] reports that, after three months of "an integrated evaluation/intervention", [the Appellant] had tolerated a return-to-work program starting May 9th, 1996. She was tolerating up to one hour and forty-five minutes but still required stretch breaks with the main limiting factor being her left low back and left hip pain. "She occasionally has some left upper shoulder and neck pain but this is less than her left hip pain". After describing the multi-disciplinary program briefly, [Appellant's physiotherapist #1] reports that [the Appellant's] progress had been slow but steady, her treatment having been interrupted by her ongoing gynaecological problem and by a cold. [Appellant's physiotherapist #1] recommends an extension of two weeks for the GRTW program. "Up to eight weeks is indicated by the occupational therapist, and [Appellant's occupational therapist] will provide you with information regarding the viability of the present job position."

> [the Appellant's] grip strength on the right is 45 pounds and on the left is 35 pounds and is associated with mild pain at the left upper trapezius. She does not present with any specific trigger points. The myofascial problem areas are left upper trapezius, left levator scapula, left quadratus lumborum, left piriformis and left gluteus medius, which respond well to heat, stretching and neuromusculature electrical stimulation.

[Appellant's physiotherapist #1] recommends a case management meeting with the occupational therapist, physiotherapist, client, [Appellant's rehabilitation director] and MPIC's adjuster if necessary, to discuss prognosis.

September 25th, 1996

[The Appellant] was re-evaluated on this date to identify any residual, objective, physical signs. She had participated in an integrated rehabilitation program for six months. Subjectively, [the Appellant] still complained of pain. She had been educated in the proper use of heat, ice and stretching to minimize pain; she had received acupuncture to trigger points and ergonomic

advice at her work station. On examination, [the Appellant] had demonstrated full range of motion of her neck and shoulders. Her back range of motion had increased and was within normal limits. Straight leg raising was 80 degrees bilaterally; muscle strength was Grade 5/5 for power. Grip strength had increased by 10% to 80 pounds on the right and 50 pounds on the left, which was within normal limits. [The Appellant] showed tenderness only in the left buttock and left low back, with no increase in muscle tension at rest in the muscles that were being treated as a result of the MVA.

[The Appellant] had therefore been discharged from active physiotherapy treatments and was to continue with her home program.

Oral Testimony of [Appellant's physiotherapist #1]

During her oral testimony to this Commission, [Appellant's physiotherapist #1] expanded upon the written reports referred to above. She emphasized that, as she put it, "We knew what we were taking on when we starting working with [the Appellant] - a patient with a low pain threshold, very pain focused and apparently suffering from pain for at least three months. That is why we planned the program for her the way that we did - home TENS unit, pool exercises, lumbar support, constant education, physiotherapy, occupational therapy, ergonomics, coping strategies and minimizing reliance on pain medications". [Appellant's physiotherapist #1] described the perceived need to improve [the Appellant's] general conditioning, with a low-resistance, light-load program, using much smaller increments than would normally have been the case.

[Appellant's physiotherapist #1] went on to say that

> [Appellant's rehab specialist #1] may have felt that our program was too aggressive, because of the frequency - three physiotherapy and pool exercises, plus two days of occupational therapy and work hardening per week - but the intensity was very light and gauged to [the Appellant's] level of tolerance. We did not use pulleys; we tried to lessen stress, addressing specific muscle groups but well below [the Appellant's] maximum potential. We would alternate stretching with strengthening, in small bites each time.

[Appellant's physiotherapist #1] reconfirmed her earlier opinion that, by September 25th, 1996, [the Appellant] was capable of returning to work. Referring to her report of September 25th, 1996, [Appellant's physiotherapist #1] explained that one can have a Grade V muscle power but without the ability to 'put that all together to perform a given task', such as gripping. A 50-pound grip strength was certainly functional for what [the Appellant] was required to do at work. [the Appellant] had told both [Appellant's physiotherapist #1] and [Appellant's occupational therapist] that she did not feel comfortable doing her stretches at her work station. However, [Appellant's physiotherapist #1] pointed out, by going to the washroom her exercises were less effective and she would be taking more time away from her work and, thus, decreasing her output.

When any of [the Appellant's] rehabilitation team had attempted to increase resistance in the course of her physiotherapy or occupational therapy, [the Appellant] would complain of too much pain and either could not or would not complete the motion asked of her.

[Appellant's physiotherapist #1] added that she and her colleagues were in regular contact with [Appellant's doctor], discussing [the Appellant's] progress and course of treatments. [Appellant's doctor] had agreed with their findings and recommendations. [Appellant's doctor] had reported, on June 28th, 1996, that [the Appellant] was having no sleep disturbance nor any

significant functional limitations in range of motion; this was well into the middle of the [rehab clinic] program.

[Appellant's physiotherapist #1] agreed that [the Appellant] was still complaining of pain when she was discharged from the rehabilitation program, although the amount of pain [the Appellant] was describing was "not congruent with our clinical findings". [Appellant's physiotherapist #1] had told [the Appellant] that she might never be completely free from pain, that she would need to use proper strategies both at home and at work by following the recommendations of her caregivers but that, if she did so, she was capable of returning to her occupation on a full-time basis.

Evidence of [Appellant's occupational therapist]

[Text deleted] is an occupational therapist [text deleted]. She first interviewed [the Appellant] on April 22nd, 1996. Her initial report of May 6th, 1996 reflects a full shoulder flexion and abduction, but painful at the end range; slight limitation of internal and external rotation and extension but equal bilaterally; elbow, forearm, wrists and hand movements were within normal limits, but a feeling of numbness down the left arm. She noted that [the Appellant] could only tolerate about half an hour of sitting still and had quite minimal ability to sit in a forward bent position.

<u>May 14th, 1996</u>

[Appellant's occupational therapist] reports attending at [the Appellant's] work site, the ergonomic changes that she had recommended, and the establishment of a schedule for a GRTW.

May 28th, 1996

[The Appellant] had begun her GRTW program on May 9th but, after an initially encouraging result, had started to report increasing difficulty with her left arm and shoulder as well as her low back. [The Appellant] appeared to feel that she was doing too much and that the combination of aquacises, physical conditioning program and return to work were too stressful. [Appellant's occupational therapist] therefore recommended that the GRTW program be delayed by a week, to allow for a physical reassessment of the Appellant. Meanwhile, [Appellant's occupational therapist] recommended that [the Appellant's] pool program at least be completed.

June 21st, 1996

At a case conference attended by the Appellant, [Appellant's rehabilitation director], [Appellant's physiotherapist #1] and [Appellant's occupational therapist], [Appellant's occupational therapist] noted that the GRTW program had been delayed by [the Appellant's] reports of increased pain in the back and left shoulder when working, gynaecological problems with associated migraines, and a flu-like illness with fever, sweats and laryngitis. [the Appellant] reported that she was now being treated for asthma with a ventolin inhaler. She had not been able to progress past one and a half to two hours at work, once or twice per week. [Appellant's physiotherapist #1] and [Appellant's occupational therapist] both felt that the Appellant should be able to progress in that area. The case conference resulted in a further visit to the work site to assess for additional, ergonomic changes, completion of the pool sessions on June 14th, continuance of physical conditioning classes plus individual physiotherapy sessions, the provision of a lumbar support and an orthotic heel lift for the Appellant's left shoe. [Appellant's occupational therapist] was to keep [Appellant's doctor] informed of [rehab

clinic's] plans. The GRTW program was to be extended by about four weeks, focusing primarily on maintaining lumbar stabilization and on the conditioning program three times per week.

June 27th, 1996

[Appellant's occupational therapist] had paid a further visit to the work site and, finding that [the Appellant] had been placed at a different work table, made arrangements for ergonomic changes at that new location. [Appellant's occupational therapist] arranged for [the Appellant] to come into the Clinic for job simulation-type activities two to three times per week for the next couple of weeks, in an attempt to reinforce her posture, training her to take proper stretch breaks, et cetera.

July 15th, 1996

In a letter to [Appellant's doctor] of this date, [Appellant's occupational therapist] reported on the steps taken by [rehab clinic] to that date. She noted that [the Appellant] "has not been able to progress in terms of hours of work. Many of the strategies suggested to manage her pain seem to work quite well, however she is reluctant to try some of them".

[The Appellant] had reported increased difficulty maintaining a sitting posture when experiencing abdominal cramping, and also experienced serious migraine headaches on a monthly basis. [Appellant's occupational therapist] asked [Appellant's doctor] whether he might have access to sample medication which, if effective, might be more within [the Appellant's] budgetary means. [Appellant's occupational therapist] mentioned the availability of a physiotherapist who could assess [the Appellant] for acupuncture treatments if [Appellant's doctor] felt it worth trying for the myofascial trigger points at the left shoulder girdle and upper

trapezius. She had resorted to written format, having been unable to connect with [Appellant's doctor] by phone.

August 12th, 1996

[Appellant's occupational therapist] reports to [Appellant's rehabilitation director] that [the Appellant's] GRTW program seemed to stall at Week 3, from July 29th to August 2nd. She had received four acupuncture treatments from [text deleted] which appeared to be offering some relief. Her left shoulder was not as problematic as her left buttock. Icing applied to the upper back had virtually eliminated the constant headaches. Her right grip was now at 75 pounds; the left one at 35 pounds. Neck and left shoulder had now full range of motion, with soft tissue pain only on end range. There were trigger points in the left levator, supraspinatous, rhomboids and left piriformis. The Appellant had reported sitting tolerance at work of 45 minutes maximum at one seating. She was inquiring about doing daycare work.

[Rehab clinic's] recommendations included a return to back-strengthening classes for one-and-a-half hours per day for two weeks, continuance of the GRTW program two days per week, six further acupuncture sessions, a one-month pool pass at [text deleted] Pool and a change in the Appellant's sleeping position to her side or back, with her arm supported.

September 16th, 1996

[Appellant's occupational therapist] reports that, following the acupuncture treatments, [the Appellant] still had some tenderpoints in her buttocks and shoulder areas but they were no longer trigger points. [The Appellant] would attend conditioning classes for a further two weeks until

September 20th, but physiotherapy treatments would be on an 'as needed' rather than a scheduled basis.

[The Appellant] had shown much anxiety at the prospect of losing her MPI financial benefits once her physical findings improved to the point where she could return to work full-time. [Appellant's occupational therapist] had explained to her that a return to work was the object of the exercise.

[Appellant's occupational therapist] concludes, in part, by saying

> ……..Its seems to me that ([the Appellant]) is functioning better overall. However return to work seems to be the one road block. She does not acknowledge all of the things which have improved over the course of her treatment until they are pointed out to her. Her ongoing anxiety around the work situation likely does not help her to cope well in that setting, as well as the lack of consistent supervision. The one new piece of information gleaned from this interview was the tension which she feels while driving, which may 'set the tone' for the rest of the day.

[Appellant's occupational therapist] recommended a further appointment with [Appellant's physiotherapist #1] for a reassessment, which took place on September 25th, 1996 as noted above.

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As a result of the foregoing assessments by [Appellant's occupational therapist] and [Appellant's physiotherapist #1], [text deleted] ([the Appellant's] Case Manager at MPIC) wrote to the Appellant on October 1st, 1996 to say, in part:

> The assessment findings failed to identify any physical impediments preventing you from continuing your rehabilitation program and gradually increasing your hours of work to

> the level you enjoyed prior to the accident. In that regard, I understand the rehabilitation program will conclude on October 18th, 1996 at which time you should be at your pre-accident level. Accordingly, at that time, in the absence of any objective physical impediments, there will be no medical basis for payment of further income replacement indemnity benefits.

Not, perhaps, entirely by coincidence, at or about the time that [the Appellant] received that letter she attended at the [hospital] where she appears to have obtained a note from the physician who was then in charge of the [text deleted] Clinic, to the effect that she was not fit to return to work.

On October 17th, 1996, we find a letter from [text deleted], a physiotherapist at [rehab clinic] who had been asked by [Appellant's occupational therapist] to reassess [the Appellant]. [Appellant's physiotherapist #2] reports that, in terms of objective findings:

> This client demonstrated limitations in neck, trunk, left shoulder and bilateral hip active range of motion and strength due to complaints of pain (a subjective complaint). Passive range of motion of the left shoulder was also limited by pain ([the Appellant] would not allow me to attempt to move the shoulder through its full ROM, however accessory movements of the shoulder were normal, indicating that capsular mobility was not impaired. The hip adductor muscles were found to be tight bilaterally and the hamstrings were tight on the left side (straight leg raise to 60 degrees). Tender points (which did not refer pain) were located in the left buttock, left spinatus, left rhomboids, left middle trapezius and left levator scapula muscles. Active trigger points were located in the left upper fibres of trapezius and supraspinatus muscles (referred pain up the side of the neck and down the arm). Of note, [the Appellant] did have some active trigger points (left shoulder girdle) and some limitation in ROM due to tight muscles (hip adductors and left hamstrings) today, which were not present in the assessment performed by [Appellant's physiotherapist #1] September 25th, 1995. As well, active ROM of the neck, trunk and left shoulder were much more limited (by pain) today.
>
> ……In my opinion, this client is still significantly deconditioned and overweight. I believe this deconditioning is likely contributing to flare-ups of myofascial pain. [The Appellant] has not continued to perform any exercises to strengthen or build muscle endurance or to improve aerobic fitness. She admits to this and agrees that she requires a 'heavy' exercise program to improve her tolerance to work…….
>
> I realize that this client has already been through a long and involved course of rehabilitation. Based on the assessment performed today, I do not feel that [the Appellant] will be able to successfully return to full-time employment next week. However, as has been the case before, this client is largely limited by pain and not

> objective findings. In my opinion, [the Appellant] needs to continue to progress the conditioning exercises she was introduced to in the classes at [rehab clinic]……I do not feel that further individual physiotherapy treatments are required. If this client decides to join an exercise facility, it might be beneficial to have a physiotherapist instruct her in choosing appropriate equipment to use and in the proper use of equipment. She may also benefit from physiotherapy visits every three weeks or so to make adjustments to this independent exercise program.

We note, in passing, the comment of [Appellant's physiotherapist #1] to the effect that [the Appellant's] suggestion that she need a "heavy" exercise program was incongruous, but we are mindful that English is not the Appellant's first language.

[The Appellant] did not attend work at all on the date when she was to have recommenced her graduated return to work.

On October 25th, 1996, [Appellant's MPIC case manager] again wrote to [the Appellant] to confirm that her income replacement benefits had been terminated as of October 18th, for the reason given in his October 1st letter.

On December 11th, 1996 [Appellant's rehabilitation director] wrote to [Appellant's doctor], setting out his understanding that [Appellant's doctor] agreed with [Appellant's physiotherapist #1] that there was not an identifiable, objective, physical impediment that would preclude [the Appellant] from returning to her pre-accident occupation. He went on to say that

> I understand that you will be referring your patient to [Appellant's rehab specialist #1] for an assessment, in order to determine whether or not he has further treatment to offer.

[Appellant's doctor] does not appear ever to have responded to [Appellant's rehabilitation director's] letter. More specifically, he does not seem to have disagreed at any time with [Appellant's physiotherapist #1's] conclusion that there was nothing to prevent [the Appellant's] return to work.

Evidence of [Appellant's physiotherapist #3]

[Appellant's rehab specialist #1] had referred [the Appellant] to [Appellant's physiotherapist #3], a physiotherapist with [hospital], on November 29th, 1997 for treatment of 'cervical lumbar myofascial pain and left frozen shoulder'. He had initially assessed her neck and shoulder which appeared to be the areas of her worst pain. He noted decreased range of movement in her neck, with extension and left rotation limited to about one-half of the normal movement. All other movements were about three-quarters of the norm. He also noted poor posture; [the Appellant] has forward rounded shoulders and chin-forward neck position. (The Appellant's poor posture was noted by several of her other caregivers.) Her left shoulder motion was limited by pain, forward flexion being 100 degrees, abduction 90 degrees and rotation also being decreased. Passive range of motion of the left shoulder was about the same as the right shoulder. "Accessory glides of the shoulder did not reveal a capsular tightness (i.e. no frozen shoulder)." Treatment included stretches for the neck and shoulder girdle, manual traction, heat and neck mobilization. Pool exercises were not included. [Appellant's physiotherapist #3] reported that, at discharge, [the Appellant's] pain-free range of motion had improved; the left rotation was now equal to that of right rotation, but she continued to complain of pain with left rotation, left side bending and extension. Left shoulder flexion was 150 degrees. [the Appellant's] attendance had been sporadic. [The Appellant] had been told by [Appellant's physiotherapist #3] that her chart would be put on hold for two weeks while she recuperated from a reported illness, but that she would then be discharged if she did not contact the department for further appointments. She agreed but, not having called the department again, she was discharged on March 9th, 1998.

At the request of her family physician, [text deleted], physiotherapy was resumed on April 21st, 1998 when [the Appellant's] main complaint was pain in her left buttock. On assessment of her lumbar spine, all movements were pain free and limited to three-quarters of normal except for forward flexion. This latter movement reproduced the left buttock pain, causing [the Appellant's] forward flexion to be reduced to 50% of the norm. That left buttock pain disappeared when in a position of lumbar extension and an extension exercise program was therefore prescribed.

On May 12th, 1998 [Appellant's physiotherapist #3] reassessed [the Appellant's] neck and left shoulder. The neck range of motion was restricted in right rotation, right side bending and extension; [the Appellant] complained of pain with right rotation only. Her posture had remained unchanged and probably led to decreased cervical extension. Shoulder assessment revealed near normal movement of the left shoulder and scapula. Pain in the region of the left shoulder blade was reproduced with left shoulder abduction at about 120 degrees. Following treatment, [the Appellant] consistently reported a decrease in pain in the area of the left shoulder blade.

As of June 3rd, 1998, [Appellant's physiotherapist #3] reported that [the Appellant] then had pain free movement of her neck; he was continuing to treat her upper and lower back which he only expected to continue for about another month. He noted that [the Appellant] now had methods whereby she could control her left buttock pain.

Evidence of [Appellant's rehab specialist #2]

[The Appellant] was next referred by [Appellant's doctor] to [text deleted], a specialist in physical and rehabilitative medicine [text deleted]. [Appellant's rehab specialist #2] saw [the Appellant] at the [hospital] on September 29th, 1998, when [the Appellant] complained of pain in her left shoulder and the left side of her back which, she said, had been present since January 1996. [Appellant's rehab specialist #2's] report of October 22nd, 1998, addressed to [the Appellant's] counsel, reaching the following conclusions:

> On examining her, I found her to be in no acute distress. She had some difficulty getting off the chair because of pain.
>
> On examining her neck the only tight muscle I found was the left trapezius. The left mid-trapezius and serratus posterior inferior had tight bands with no active trigger points. She complained of tenderness only over the trapezius, the mid-trapezius and the serratus posterior inferior.
>
> She had no other active trigger points or tenderness in her upper back or chest area. She also had some tightness of the left scalene muscle. She had good mobility of her neck in all directions except for lateral flexion secondary to the scalene tightness. She had full mobility of her left shoulder except she complained of pain on elevation. She also complained of pain on internally rotating the shoulder.
>
> She had no evidence of atrophy of any of the muscles around her shoulder girdle, in fact her forearm girth on the left side is better is on the right side, but this is related to her dominance.
>
> The reflexes were equal and bilaterally and there was no sensory deficit.
>
> My impression was that she was still complaining of persistent pain in the muscles around the shoulder girdle and neck area, without any evidence of active trigger pints at the time that I saw her to suggest that she was having any residual myofascial pain syndrome. The only advice I had for her was to continue with her exercise program and to find an appropriate job for her which did not require her to do repetitive bending or heavy lifting or sitting in one static position for long periods of time. I feel that she would be able to manage a job where she was allowed to move around and be able to stretch at least once in two hours.

Evidence of [MPIC's doctor]

[MPIC's doctor], Medical Director of MPIC's Claims Services Department, had reviewed the material on [the Appellant's] file on several occasions. His written views may be summarized this way:

October 28th, 1997

After reviewing and summarizing the reports of [Appellant's doctor], [Appellant's physiotherapist #1], [Appellant's occupational therapist], [Appellant's orthopaedic specialist], [Appellant's physiotherapist #2] and [Appellant's rehab specialist #1] up to this date, [MPIC's doctor] expresses the view that:

(a) the asymmetrical gait described by [Appellant's rehab specialist #1] must have developed after [the Appellant's] attendance upon [Appellant's orthopaedic specialist], who had described a symmetrical gait with no visible limp;

(b) the decreased range of motion in [the Appellant's] left shoulder, described by [Appellant's rehab specialist #1], must have developed more than one year after [the Appellant's] accident and would not be considered related to her accident;

(c) there was no apparent explanation for the different views of [Appellant's rehab specialist #1], who had reported no significant abnormalities from an X-ray of [the Appellant's] left shoulder, and that of [Appellant's orthopaedic specialist] whose report described early degenerative change at the acromioclavicular joint of [the Appellant's] left shoulder;

(d) given [the Appellant's] age, occupational exposure, weight (she had been described by some of her caregivers as grossly overweight), body habitus and the degenerative changes identified in her acromioclavicular joint of her left shoulder and of her thoracic spine, many of her complaints were not related to her motor vehicle collision;

(e) [MPIC's doctor] points to [Appellant's physiotherapist #1's] documentation in September 1996, describing no significant musculoskeletal sequelae of the MVA, and to [Appellant's orthopaedic specialist's] report which describes similar lack of impairment. [MPIC's doctor] felt that, in June and in September of 1996, at least, there had been no physical findings that would have prevented a return to work by [the Appellant]. The trigger points and taut bands described by [Appellant's rehab specialist #1] were common in the general population and could not be considered to lead to impairment or disability.

March 19th, 1998

In a memorandum that primarily responds to some comments of [Appellant's rehab specialist #1's], [MPIC's doctor] notes that "It does not appear that [Appellant's rehab specialist #1] takes issue with the causation for this patient's identified trigger points, nor does he comment on this patient's impairment".

July 9th, 1999

In a further review of the file and, in particular, referring to [Appellant's rehab specialist #1's] letter of June 8th, 1998, [Appellant's physiotherapist #3's] letter of June 3rd, 1998 and [Appellant's doctor's] letter of May 25th, 1999, and after pointing to a number of areas in which the views and findings of [Appellant's rehab specialist #1] diverged from those of [Appellant's orthopaedic specialist], [Appellant's physiotherapist #1] and [Appellant's physiotherapist #2], [MPIC's doctor] concludes:

> There is evidence that this patient had a substantial improvement in symptoms through the period of May to September 1996. There are limited objective findings relating her complaints to a single episode of motor vehicle trauma. There is evidence that unrelated conditions such as thoracic degenerative disk disease, lumbar degenerative disk disease, left AC (*acromioclavicular)* joint arthropathy, poor posture, obesity, deconditioning and

> previous motor vehicle collision-related problems and work-related problems are affecting her musculoskeletal system.
>
> The most consistent diagnosis for her current complaints, subsequent to the September 1996 documentation of good functional capacity, has been chronic regional myofascial pain syndrome. The cause of regional myofascial pain syndrome is unknown. It can be related to postural problems, which this patient manifests. It can be related to workplace exposure. It can be related to trauma. It can be related to cooling of the muscles, and other factors.

[MPIC's doctor] expresses the opinion that there is insufficient evidence to establish a probable cause and effect relationship between [the Appellant's] current diagnosis of chronic regional myofascial pain syndrome and the motor vehicle collision in question. He notes that [Appellant's rehab specialist #2] does not document any significant myofascial pain syndrome, nor any significant impairment.

[MPIC's doctor's] Oral Testimony

When called as a witness at the hearing of [the Appellant's] appeal, [MPIC's doctor] essentially confirmed the several opinions that he had expressed by earlier memoranda. He agreed with [Appellant's rehab specialist #1] that myofascial pain syndrome is a treatable condition which, when frequently found in the general population, generally attacks those same muscles that are involved in [the Appellant's] case. The condition is normally characterized by a number of so-called 'trigger points' on the patient's body which, when subjected to reasonable firm palpation, cause referral of pain to other, specific areas. That is to say, pain at a given location can be reproduced by pressure on another specific location. Myofascial pain syndrome is almost always accompanied by taut bands of musculature, most frequently in the upper trapezius, thoracic iliocostalis and quadratus lumborum muscles. Medical science has not yet been able to determine, with any reliability, the etiology of myofascial pain syndrome; it does not necessarily denote disability, in any event.

In referring to [Appellant's physiotherapist #1's] report of September 25th, 1996, [MPIC's doctor] expressed the view that six months is an unusually long time for someone with [the Appellant's] physical signs to participate in an integrated rehabilitation program. He felt it significant that [the Appellant] was described as having a full range of motion of her neck and shoulders by that date. In the absence of a neurological problem or a compressed fracture, the findings of all of [the Appellant's] caregivers to that point clearly indicated the wisdom of a return to work.

[MPIC's doctor] pointed out that, in keeping with the findings of [Appellant's orthopaedic specialist], neither [Appellant's rehab specialist #2] nor [Appellant's physiotherapist #3] had found any trigger points, nor a "frozen shoulder" and that [Appellant's physiotherapist #3] had found a full passive range of motion of [the Appellant's] shoulder.

The joint recommendations of [Appellant's rehab specialist #1] and [Appellant's clinical nurse specialist in rehabilitation] were essentially the same as those that had been recommended and given effect by [Appellant's physiotherapist #1] and [Appellant's occupational therapist].

[MPIC's doctor] agreed that the trauma of a motor vehicle accident could cause myofascial pain, although he felt it unlikely in [the Appellant's] case. He agreed that, although [Appellant's physiotherapist #2] had suggested a possible need for psychological intervention, that did not seem to have been communicated to [text deleted], the Case Manager at MPIC, or, if communicated, it did not appear to have been acted upon. [MPIC's doctor] agreed that this should have been followed up.

[MPIC's doctor] emphasized his view that, for someone with the apparent symptoms of [the Appellant], exercise was therapeutic and the lack of it was counterproductive. He felt that [the Appellant's] deterioration was in all probability due, in the main, to the cessation of her home exercises.

Discussion

There were several factors which undoubtedly served to retard [the Appellant's] recovery.

1. Firstly, she has a lengthy history of musculoskeletal problems, extended over the last twelve years. Included in that history were some lengthy absences from work due to previous motor vehicle accidents and work-related injuries. In July, 1993, [text deleted], a specialist in rehabilitation medicine, one of [the Appellant's] numerous caregivers involved as a result of a November 22nd, 1991 MVA, said

   ……It is almost two years now since her accident. She does have residual myofascial pain secondary to her motor vehicle accident…..This is a problem that will likely flare up from time to time depending on her level of activity, condition of the weather, et cetera, but is not one which will get progressively worse with time and lead to arthritis or any other type of muscle degenerative problems.

   I strongly advised her to return to work starting four hours a day and increasing to six, eight, ten hours at two week intervals.

   Similarly, a report from [text deleted], a specialist in orthopaedic and traumatic surgery, in January 1988 describes symptoms that are in many ways almost identical to those resulting from her 1996 accident, the principal difference being that, in 1987 and in 1991, her shoulder problems appear to have been on the right side. It is, perhaps, noteworthy that [Appellant's orthopaedic and traumatic surgery specialist] found [the Appellant] to

be capable, when distracted, of a full and complete range of rotation of her neck, although she was only willing to demonstrate about 30 or 40% of normal rotation when specifically asked to do so. She is also reported by [Appellant's orthopaedic and traumatic surgery specialist] as having stated that she was right-handed.

2. [Appellant's rehab specialist #1], in his evidence, said that, in the early stages of rehabilitation, the use of pulleys by the patient was contra-indicated. The file indicates that [the Appellant] was, in fact, working with reciprocating pulleys at [physiotherapy clinic] during the first few months after her accident, until [Appellant's physiotherapist #1] and her team became involved and discontinued their use immediately.

3. While it seems clear that [the Appellant's] recovery progressed well while she was under supervision, it seems equally clear that, until recently at least, she was not capable of self-discipline and of following instructions for home exercises given to her by her physiotherapists. [The Appellant's] counsel suggests that there is no evidence to support the proposition that she had not been doing her home exercises, but, with respect, there is the report of [Appellant's physiotherapist #2] (who says flatly that [the Appellant] acknowledged her failure to do her exercise program) and there is the obvious deconditioning that resulted from that failure.

4. The report of [Appellant's physiotherapist #3] indicates that [the Appellant] was discharged from physiotherapy at the [hospital] on March 9th, 1998 due to her own failure to arrange for further appointments and, when readmitted to the program at [Appellant's doctor's] request on April 21st, 1998, she was still not following directions respecting of her posture.

5. [The Appellant's] decision during her GRTW program to attempt her exercises within the narrow confines of a washroom cubicle is difficult to comprehend, particularly since she

> had a sympathetic employer and her co-workers only needed a simple explanation. Her exercises, if performed at all under those circumstances, must have been inhibited by limitations of space, further hindering the speed of her recovery.

On the other hand, it has to be said that, with the possible exception of psychological intervention (for which the need, medically speaking, was obliquely suggested but unclear), MPIC has indeed been totally supportive of the Appellant. We do not accept [Appellant's rehab specialist #1's] suggestion that no one was listening to [the Appellant], and his accusation that MPIC was only interested in saving money and that its rehabilitation program was too aggressive is not borne out by the evidence. [Appellant's physiotherapist #1's] testimony, in particular, tells us that the caregivers whose work for [the Appellant] was funded by MPIC were using their best efforts to ensure that too much was not being demanded of her. The reports of her physiotherapists and occupational therapists indicate a sensitivity to her complaints of pain and, although they undoubtedly believed that she was capable of greater achievement than she, herself, was ready to acknowledge, they appear to have backed off appropriately when required to do so.

While [Appellant's rehab specialist #1] criticizes the earlier treatment modalities offered to [the Appellant] by the team at [rehab clinic], his own do not appear to have been markedly different, save only for the Cyclobenzadrine, a muscle relaxant. Prior to that, [Appellant's doctor] had been prescribing Voltaren, a form of anti-inflammatory analgesic. [Appellant's rehab specialist #1] had also injected Xylocaine on either one or two occasions (he says once, [the Appellant] says twice); [the Appellant] testified that each injection had given her relief from pain for about one and one-half days.

We are troubled by the fact that [Appellant's rehab specialist #1's] reports, commencing more than a year after [the Appellant's] accident, differ materially from the reports of almost all other caregivers.

[Appellant's rehab specialist #1] agrees that, in the normal course, [the Appellant's] symptoms are more likely to have been caused by the constant, repetitive movements required by her job than by one, single event. However, he points out, he is obliged to believe his patient when she says that she was totally symptom-free before her accident and he asks, rhetorically, "What else could have caused her shoulder, neck and back problems other than the MVA which bore such a close, temporal relationship to them?"

The report of [Appellant's physiotherapist #3] shows only one-half of normal range of motion of [the Appellant's] neck and three-quarters of all other normal movements. However, assessments made closer in time to the MVA show almost total range of motion. Even [Appellant's physiotherapist #3], in June of 1998, foresees a return to work by the end of July.

It might be argued that an accident victim with the prior, lengthy absences from work (and the income derived from MPIC and the Workers' Compensation Board as a result) experienced by [the Appellant] may have created:

(i) a physical predisposition to reinjury;

(ii) latent conditions making recovery from that reinjury a much longer process than the norm; and

(iii) a reluctance, conscious or otherwise, to acknowledge rehabilitation to a degree that would allow GRTW, knowing that such an admission would necessarily result in the drying up of funds.

However, while those first two factors were present in [the Appellant's] case, and while there is certainly evidence of the third, we are not prepared to find that [the Appellant] was purposefully malingering. When able, she appears to have been a hard and conscientious worker. The evidence of [Appellant's supervisor] supports the Appellant's own testimony that she was, if anything, an over-achiever in the workplace. She well exceeded the minimum requirements of her employer and had earned more money when employed than she received in income replacement indemnity. She twice sought a return to lighter work at [text deleted] and even tried an actual return to work as a sewing machine operator at [text deleted] in January of 1999, but only lasted for a couple of weeks. Eventually, following the advice of [Appellant's rehab specialist #2] - advice that she had been receiving from [Appellant's doctor] for several years - she found a job with less repetitive bending, heavy lifting and sitting in one static position for long periods of time.

While [Appellant's doctor], [Appellant's physiotherapist #1] and [Appellant's occupational therapist] all agreed that further, individual physiotherapy in September/October, 1996 was not required - even [Appellant's rehab specialist #1], in March, 1997, had prescribed general counseling by [Appellant's clinical nurse specialist in rehabilitation], the introduction of stretching exercises at home and, if [the Appellant] had not improved within two or three weeks, then he would consider outpatient physiotherapy - they all spoke of the need for the resumption or continuance of home exercises. We find, from the evidence of [Appellant's physiotherapist #2] and from [the Appellant's] obviously deconditioned state, that she had not been doing those

exercises and, once the supervised rehabilitation program was discontinued, had regressed. To that extent, she was the creator of her own misfortune.

If [Appellant's rehab specialist #1] and [Appellant's clinical nurse specialist in rehabilitation] found it necessary to educate [the Appellant] in home exercises, that is further evidence that she had obviously not been compliant. As a result, she quickly became further deconditioned. The later efforts of [Appellant's rehab specialist #1], [Appellant's clinical nurse specialist in rehabilitation] and [Appellant's physiotherapist #3] brought her back to the same condition that she had reached in mid-October, 1996.

[The Appellant] is a lady who, by reason of her medical and employment history of the ten or twelve years preceding her 1996 MVA, her obesity and her serious deconditioning needed more than the normal amount of therapy, in the broad sense of that word. She received that extra support to a major extent and for roughly twice the normal timeframe.

This Commission is, not for the first time, placed in the position of having to use the wisdom of hindsight to determine whether [the Appellant] had reached the employable condition that she now enjoys by October 25th, 1996. A review of the entire body of evidence presented to us, combined with the observation and experience of the members of this panel since this Commission was established in early 1994, forms the basis of our findings.

We find, on a reasonable balance of probabilities, that:

(i) [the Appellant's] temporary impairment resulting from the pain in her left shoulder and, to a lesser extent, in her lumbar region was a result of her January, 1996, MVA and rendered it impracticable for her to return to her former employment until October, 1996;

(ii) at the time her benefits were terminated by MPIC, [the Appellant] needed, not more physiotherapy at that stage but, rather, the continuance of her home exercise program which, from the evidence of [Appellant's physiotherapist #2], the Appellant had already abandoned; it was up to the Appellant to decide for herself whether to continue her exercises at home or, if she wanted even more supervision, to attend a gymnasium or other program at her own expense;

(iii) if [the Appellant] did develop adhesive capsulitis - a matter of some doubt - it was of short duration and brought about by her own failure to continue her home exercise program. (Although [Appellant's rehab specialist #1] diagnosed that condition for the first time in or about June, 1997, and referred her to [Appellant's physiotherapist #3] for physiotherapy, by November 29th, 1997, [Appellant's physiotherapist #3] could detect no signs of it - quite the contrary);

(iv) from the evidence of [Appellant's rehab specialist #2] and [Appellant's physiotherapist #3], [the Appellant] was capable by June 30th, 1998, at the latest, of the employment she now holds; if we accept that (as we do), and if we also accept that her condition on June 30th, 1998 was much the same as it had been on October 26th, 1996, it follows that she was capable of that employment when her IRI was terminated.

DISPOSITION:

For the reasons set out above, we find that the Appellant was not prevented from returning to her employment by physical disability caused by her motor vehicle accident. The continuance of that disability beyond October 26th, 1996, if it existed, was due primarily to her own failures to

(a) follow the advice of her caregivers in the context of her posture, pain control methods and exercise during her GRTW program, and

(b) adhere to the course of home exercises for which she had received extensive counseling.

It follows that [the Appellant's] appeal must be dismissed.

Dated at Winnipeg this 17th day of November, 1999.

J. F. REEH TAYLOR, Q.C.

CHARLES T. BIRT, Q.C.

LILA GOODSPEED