Automobile Injury Compensation Appeal Commission

IN THE MATTER OF an Appeal by [the Appellant]
AICAC File No.: AC-97-117

PANEL:	**Mr. J. F. Reeh Taylor, Q.C., Chairman** **Mr. Colon Settle, Q.C.** **Mrs. Lila Goodspeed**
APPEARANCES:	**Manitoba Public Insurance Corporation ('MPIC') was represented by Mr. Keith Addison;** **the Appellant, [text deleted], was represented by [Appellant's representative]**
HEARING DATE:	**February 7th, 2000**
ISSUE(S):	**(i) Whether injuries related to motor vehicle accident (MVA);** **(ii) Whether treatments appropriate and medically necessary;** **(iii) Whether MVA-related injuries made cessation of work necessary.**
RELEVANT SECTIONS:	

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

The Appellant, [text deleted], seeks Income Replacement Indemnity for the period during which she was receiving chiropractic treatments and not working, as well as reimbursement at the rates applicable to chiropractic treatments in Manitoba for treatments she received in [text deleted], Texas. In order to give full play to the position advanced on behalf of [the Appellant], a careful analysis of the evidence available to us is required.

EVIDENCE OF THE APPELLANT:

[The Appellant], [text deleted] years of age at the time of her accident on April 5th, 1995, had worked as a [text deleted] for five or six years until, in the fall of 1993 and through the spring of the following year, she trained as an [text deleted]. She testified that, at the time of her MVA, she was earning about $7 per hour and working a 40-hour week. In early 1996, her employer had apparently decided to close her business. [The Appellant] offered to buy it, and the purchase took place in February 1996. She testified that, by the time she closed her business (as will later appear), she was grossing about $35,000 annually. In the meantime, she had been subjected to two robberies at knifepoint. All of these factors—the potential job loss, the responsibilities of ownership, and the robberies—had greatly increased the stresses of her daily living.

[The Appellant] gave evidence of the relevant portions of her pre-MVA medical history. In 1989, her vehicle had been broadsided by another, as a result of which she sustained a whiplash associated disorder and received chiropractic treatments from [Appellant's chiropractor #1] whose records show that, from November 17th to December 30th, 1989, both inclusive, she received 32 chiropractic treatments, followed by another 198 treatments in 1990, 23 in 1991, seven in 1992, 63 during a six-month period in 1994, and 19 during the first two months of 1995.

[the Appellant] further testified that, in 1993, she had been hit by a car while on her cycle; this, she testified, resulted in "problems with my neck, back and legs." [The Appellant] was obliged to use crutches and, with her sore neck and back, was unable to work with children for a couple of months. During the two years following that 1993 accident, she was attending physiotherapy on a regular basis, and MPIC paid her medical and paramedical expenses as well as the salary that she lost while away from her work. Her claim under the former tort system was apparently

settled in the spring of 1994, when her physician and physiotherapist felt that she no longer needed treatments.

Prior to her MVA on April 5th, 1995, [the Appellant] was attending upon [text deleted], chiropractor, for what she describes as "help in everyday living, to maintain good health." She did a lot of running and engaged in hard workouts; as a result, [the Appellant] explains [Appellant's chiropractor #2's] references (noted later in these reasons) to her leg and ankle pain as being related to everyday living rather than to any particular traumatic event.

At the time of her accident, [the Appellant's] vehicle was stopped at a four-way stop sign when it was rear-ended by a half-ton truck. The impact pushed her vehicle approximately one-quarter of the way into the intersection. She said "I don't even know if there was any damage to the truck; there was only minor damage to mine. I know that instantly my back and neck hurt, and my left leg just above the ankle." *(The record indicates that the cost of repairing [the Appellant's] car was approximately $160.)* She had driven from the place of the accident to the home of her mother, who drove her to the [hospital] where they X-rayed her neck and sent her home with some anti-inflammatory medication. On the following day, while being still sore from her accident, she went to see [Appellant's chiropractor #2], whom she had been seeing at a frequency of about ten times per month even prior to her accident. She had no family physician at the time. After the accident, [Appellant's chiropractor #2] gave her some spinal adjustments and gave her some exercises to do at home.

[The Appellant] testified that she carried on with all her work-related activities following the accident, taking only one day off work on April 6th, 1995. However, she said, she had to cease most, if not all, of her extracurricular activities that summer; she had tried going back to curling

the following winter, but found it too painful. Meanwhile, she was seeing [Appellant's chiropractor #2] two to three times per week. Those treatments would give her very short-term relief, but return to work brought symptoms back immediately. [Appellant's chiropractor #2] had told her that her neck and back problems were caused by her MVA, and that her leg problem was caused by the neck injury. After two years of treatments from [Appellant's chiropractor #2], [the Appellant] was becoming frustrated; her leg seemed to be getting worse rather than better. When, after two years, MPIC terminated her chiropractic benefits, [Appellant's chiropractor #2] was still telling her that he would get her better. "He had told me to work less hours, so I had cut back to a four-day work week."

On July 30th, 1996, [the Appellant] was referred by her adjuster at MPIC for an independent chiropractic examination and assessment by [independent chiropractor], who saw [the Appellant] on September 16th, 1996. Amongst [independent chiropractor's] recommendations was the suggestion that she should obtain the services of a general practitioner and so she consulted [Appellant's doctor #1] who, in turn, sent her to [Appellant's sports medicine specialist]. [Appellant's sports medicine specialist] examined [the Appellant] and then sent her for a magnetic resonance image of her leg which, she testified, "came back fine." [Appellant's sports medicine specialist] referred her to [Appellant's plastic surgeon] at the [text deleted], a specialist in general plastic, micro and reconstructive surgery, who expressed the possibility that the problem she was having with her left lower extremity could be related to an injury sustained in a motor vehicle accident. [Appellant's plastic surgeon] had advised [the Appellant] that he saw no need for surgery.

By March of 1998 (three years post-MVA), said [the Appellant], things were getting progressively worse. She was having difficulty sleeping due to leg pain; she was having

persistent headaches; she could not keep food down; and she ached all over. [Appellant's chiropractor #2] then decided to give her oxygen which she used every morning and evening. He also prescribed the use of a heart monitor which beeped when she overexerted herself. In that same month, [the Appellant] started teaching on a part-time basis at [text deleted] where, during 1998, she earned $2,948 from teaching.

In or about the month of April 1998, [Appellant's chiropractor #2] referred [the Appellant] to [text deleted], a chiropractic neurologist in [text deleted], Texas. She did not discuss her [Texas] trip beforehand with her adjuster, nor with [Appellant's doctor #1] nor, indeed, with any caregiver in Manitoba other than [Appellant's chiropractor #2]. The Appellant was first examined by [Appellant's chiropractic neurologist #1] on May 11, 1998. What was initially intended to be a one-week visit to [Appellant's chiropractic neurologist #1's] clinic was extended to May 23 and, as a result, [the Appellant] obtained relief in all areas of her former discomfort, other than her left lower leg and ankle.

Upon her return to [Manitoba], [the Appellant] went back to consult her family doctor, [Appellant's doctor #1], who, she said, supported her in her decision to continue with chiropractic treatments. [text deleted]

The Appellant further testified that she returned to [Appellant's chiropractor #2] but, once she had recommenced work, her symptoms recurred and became worse. She spoke with [Appellant's chiropractic neurologist #1] every few days, and [Appellant's chiropractic neurologist #1] tried to help by altering the way that she completed certain tasks domestically. Since that did not work, [Appellant's chiropractic neurologist #1] suggested a conference with a [text deleted], a chiropractic neurologist in [text deleted], Texas. [The Appellant], therefore,

went to [Texas] September 4, 1998, where she was examined by [Appellant's chiropractic neurologist #2] during 'Grand Rounds.' [Appellant's chiropractor #2], who had apparently also travelled south for the purpose, was present during this examination, as was [Appellant's chiropractic neurologist #1]; the examination was videotaped. [The Appellant] related that [Appellant's chiropractic neurologist #2] had confirmed that it was her neck problem that caused her leg pain; he recommended that she be given a different kind of adjustment to her neck, in addition to some other recommendations that he advanced. The Appellant remained in Texas until September 14th under treatment from [Appellant's chiropractic neurologist #1], and then returned to [Manitoba] again, keeping in touch with [Appellant's chiropractic neurologist #1] by telephone almost on a daily basis, but continuing to see [Appellant's chiropractor #2] every day for the first week following her return. Although [Appellant's chiropractor #2] concentrated on following [Appellant's chiropractic neurologist #2's] recommendations, after her return to work [the Appellant's] problems again escalated. Therefore, in one of her daily conversations with [Appellant's chiropractic neurologist #1], [the Appellant] was told that "she could help me but I would have to take two months off and go down to [Texas]."

Meanwhile, [the Appellant] had started seeing a psychiatrist, [text deleted], to whom she had been referred by [Appellant's chiropractor #2] for psychological evaluation and assistance with her apparent sleep disorder. [Appellant's psychiatrist] had diagnosed clinical depression and had prescribed an antidepressant, but [the Appellant] declined the use of that medication. [Appellant's psychiatrist] had also suggested, as a natural alternative, L-tryptophane, but [the Appellant] declined that as she did not consider herself depressed. The Appellant testified that [Appellant's psychiatrist] agreed that she could omit medication, unless her condition deteriorated to a greater extent. [The Appellant] attended upon [Appellant's psychiatrist]

initially in November or December of 1998 and, it appears, sporadically until sometime in July of 1999, when [Appellant's psychiatrist] discharged her.

[The Appellant] further testified that, in September 1998, following [Appellant's chiropractic neurologist #1's] suggestion that she take two months off and go down to [Texas], she had tried to find someone to run her business for her during that period. Being unable to find anyone, she had put the business up for sale, aiming for a sale in January of 1999. Having no luck in that effort, either, she decided to close the business. [Text deleted] agreed to keep her position open for her so she decided that, once she got home from [Texas], she would go back to teaching and would work for someone else if she felt up to it. None of her caregivers had suggested any career change.

The Appellant returned to [Texas] in January 1999. She did so, apparently, because [Appellant's chiropractic neurologist #1] and [Appellant's chiropractic neurologist #2] felt that the concept of following [Appellant's chiropractic neurologist #2's] recommendations while she, the patient, was living in [Manitoba], "just wasn't working. I felt that [Texas] was where I had to be." [The Appellant], therefore, drove down to [Texas], accompanied by a friend who stayed with her for her first week there. Upon her arrival at [Texas] on the afternoon of January 19th, 1999, she went straight to [Appellant's chiropractic neurologist #1's] clinic because, as she put it, "I was in pretty poor shape." She testified that her leg was swollen and sore, her back and neck were sore, she could not keep food down, and only slept a few hours per week—"some nights I didn't sleep at all." [The Appellant] stayed in [Texas] for two months, attending the [text deleted] Chiropractic Clinic five days per week from 9 a.m. until 4 or 5 p.m. By the end of her time there, she had received 128 treatments, her neck and back were pain-free, she was sleeping better and, although her leg was still somewhat painful, she recalled that [Appellant's chiropractic

neurologist #1] had always told her that the leg pain would be the last thing to disappear. She describes the pain as being 'deep,' inside her leg, above the ankle, and toward the side of her leg. She was also now able to keep her food down. Her mother flew down and came home with [the Appellant] when she drove back to [Manitoba].

[The Appellant] went on to say that the plan prescribed for her, upon leaving Texas, was for her not to return to work right away. On the other hand, she needed no more chiropractic adjustments, she was told, and if she kept up the home program given to her by [Appellant's chiropractic neurologist #1's] clinic, she would get better and eventually return to work. She was to keep in touch with [Appellant's chiropractic neurologist #1] on a regular basis and, between them, they would be able to decide upon an appropriate date for a return to work. They kept in touch by phone and by e-mail, but [the Appellant] had no further treatments.

Having been away from the workplace for nine months, [the Appellant] returned to work on October 1st, 1999. She telephoned her old clients, and most of them apparently came back to her. She had started working four days per week on a part-time basis, and this had caused a slight setback but, on the advice of [Appellant's chiropractic neurologist #1], she had adjusted both the nature and the frequency of some of her home exercises, and she quickly felt fine again.

By the time of the hearing of her appeal, [the Appellant] was able to testify that she was again teaching [text deleted] and working six days a week. Apart from being rather tired, she felt fine and "pretty close to 100 percent." She follows an exercise video she obtained from [Appellant's chiropractic neurologist #1], doing those exercises twice a week, using a stationary bicycle, doing 'curl-ups," she has no sleep disorders, a good appetite and, in general, "feels great."

She had had a CT scan performed in [text deleted], North Dakota, at the request of [Appellant's chiropractic neurologist #2] on her way down to [Texas], and an MRI done in [Texas] at a cost of US$500.

[The Appellant] had been examined in [Manitoba] by [Appellant's rehab specialist] in the spring of 1998, upon the advice of her attorney, as part of her efforts to find out what was wrong with her.

[The Appellant] agreed that she had been seeing [Appellant's chiropractor #2] both before and after her 1995 MVA. Prior to that accident, she had sustained ankle and leg problems from her 1993 accident, and [Appellant's chiropractor #2] would adjust her ankle joint.

THE EVIDENCE OF [APPELLANT'S CHIROPRACTOR #1]:

In a report to MPIC dated May 3rd, 1995, [text deleted], chiropractor, noted that [the Appellant] had been attending his office for treatments since 1990. She had previously been treated for whiplash associated disorder which had subsequently resolved. As a result of her accident of April 5th, 1995, she had developed head and neck pain and stiffness, with a moderate, constant headache, mid-back pain and sore, stiff muscles and joint. He felt she was capable of resuming her main occupation of [text deleted], that she was not disabled, and that she would need treatments two or three times per week for six weeks before being re-evaluated. In a discussion with MPIC's adjuster in charge of [the Appellant's] claim, [Appellant's chiropractor #1] is reported to have said that [the Appellant] "had had lots of care" from him since 1990—over $1,400 worth in 1994/95, and that she had had "lots of problems, treatment was for mostly bad headaches not MVA-related, which are almost constant." In a further report, resulting from an apparent discussion between [Appellant's chiropractor #1's] office and [text deleted], one of

MPIC's chiropractic consultants, it is noted that [the Appellant] had been treated by [Appellant's chiropractor #1] for a November 17th, 1989, motor vehicle accident from November 1989 to August 1st, 1990, during which time she received 161 treatments. Having settled that claim on August 14th, 1990, [the Appellant] had received a further 37 treatments to the end of 1990, some 16 treatments sporadically through 1991, and a few more in 1992.

[Appellant's chiropractor #1] had referred X-rays of [the Appellant's] spine to a [text deleted], a chiropractic radiologist in [text deleted], California. [Appellant's chiropractic radiologist's] report to [Appellant's chiropractor #1] refers to X-rays taken on April 5th, 1995, at [hospital] in [Manitoba]. With respect to [the Appellant's] cervical spine, [Appellant's chiropractic radiologist] noted that there was no evidence of any recent fracture nor of gross osseous pathology, that disc spaces were well maintained, and that anterior soft tissue markings were within normal limits. He concluded that a decrease in range of motion was noted, suggesting the possibility of underlying paravertebral muscle spasm; clinical correlation was necessary, he felt.

With respect to the Appellant's thoracic spine, [Appellant's chiropractic radiologist] noted a "left to right curve" but no other abnormalities.

As to her lumbar spine, he found a minimal right convex curve, facet arthrosis at L4/S1, and four true lumbar segments.

[Appellant's chiropractor #1] noted that [the Appellant] had missed one day of work on Thursday, April 6th, as a result of her accident.

EVIDENCE OF [APPELLANT'S CHIROPRACTOR #2]:

[Appellant's chiropractor #2] has rendered several reports to MPIC with respect to his diagnoses and treatments of [the Appellant].

October 30th, 1995: This seems to have been the first date upon which a written report was rendered by [Appellant's chiropractor #2], although it later appeared that he had first seen the Appellant in connection with her motor vehicle accident on August 3rd of that year. He diagnoses "chronic post-traumatic moderate-severe left ankle pain, (illegible) swelling resulting from autonomic concomitant dysfunction secondary to thalamic hyperpolarization resulting from cervical, thoracic and lumbosacral zygapophyseal articulation pathomechanics resulting from traumatic vehicle accident." In this report, [Appellant's chiropractor #2] notes that the Appellant is complaining of headaches and lower back pain. The prescribed treatment consisted of "postneurophysiological assessments, chiropractic coupled with manipulative reductions to joints demonstrating pathomechanics and associated fast stretch of appropriate musculature. Rehabilitative activities daily with electrical modalities as necessary." [Appellant's chiropractor #2] also noted that he had not referred the victim to a specialist, because she "has already been to numerous physicians." *(The basis of this last comment is unclear, since it is unsupported by any other evidence, including that of the Appellant herself.)* [Appellant's chiropractor #2] expressed the view that [the Appellant] was capable of resuming her main occupation, although prolonged standing or sitting would aggravate her condition.

February 13th, 1996: [Appellant's chiropractor #2] reports "chronic left lower extremity severe pain, secondary to decreased neuronal afferentation to anterior tibial and other [illegible] left lower extremity musculature. Associated autonomic concomitant with decreased vascular return secondary to pre-synoptic decreased frequency of firing to the thalamus and interomedial lateral cell column of the spinal cord. Resulting from a loss of zygapophyseal ligament instability in the cervical, thoracic and lumbosacral spine. Cephalgia and trapezius myospasms also present.

Condition improving but not yet stabilized. Hypoxia present but improved. Ongoing rehabilitation and treatment with gradual improvements noted."

May 27th, 1996: In response to a request from MPIC for a short narrative report, [Appellant's chiropractor #2] first relates his findings when [the Appellant] first attended at his office on August 3rd, 1995. She had spoken of immediate pain and swelling in her left ankle and localized pain in her low back with burning and pulling sensations into the back of her neck from the occiput down over the bilateral trapezius muscles and into her rhomboids and mid-thoracic region. This was followed over time by severe headaches, throbbing, with a constant tightness and occasional stabbing pains on head motion. [the Appellant] had told him that, between April 5th and August 3rd, 1995, she had become more sensitive to bright lights, had noticed blurring of vision and associated "fogginess." Muscle aching had become more constant, neither medication nor massage had brought relief, she was easily fatigued with progressive upper body pain, but the most serious symptoms were in her left ankle.

[Appellant's chiropractor #2] then spells out in detail the results of a comprehensive physical examination that he had performed on [the Appellant] on May 24th, 1996, which appears to be the first time that this had taken place. At this juncture, [the Appellant] continued to indicate swelling of her left ankle, exacerbated by prolonged standing. She was wearing a "foot-drop support" on her left lower extremity. She was still complaining of frequent cephalgia (i.e., headaches) and nausea which collectively worsened by the end of a full working day. The foot-drop brace that she had been wearing since January 3rd, 1996, had apparently brought "immediately relief in her symptomatology." Subsequent treatments revealed ongoing improvements with decreased swelling and pain observed in her left lower extremity below the knee, said [Appellant's chiropractor #2].

In a somewhat self-contradictory paragraph, [Appellant's chiropractor #2] notes that, in March 1996, the patient once again began to experience symptomatology, including facial, for the first time on record, numbness and right ear pain, with occasional dizziness upon getting up. She had noticed that this was worse with prolonged work activities. Her sleep, once again, improved, and her overall condition was stabilizing—improvements that were continually noted throughout the month of March. [Appellant's chiropractor #2] goes on to say:

> As her condition continued to improve, she was prescribed isotonic rehabilitative activities, cerebellar activities, hemifield visual stimulation and auditory evoked potentials, in order to stabilize her nervous system and subsequently provide appropriate efferent stimulation to the musculature and autonomic concomitants.

The maneuvers apparently suggested by [Appellant's chiropractor #2] to help stabilize the Appellant's condition seem to have resulted in some exacerbations, and she was, therefore, instructed to decrease her workload and adjust her schedule so as to decrease the amount of aggravating factors that were limiting her healing process. The nature of these 'aggravating factors' is not made clear. Enough to say that [the Appellant] starting working fewer hours but started hyperventilating or, as [Appellant's chiropractor #2] puts it, was "demonstrating pronounced aberrancies of respiratory mechanics…decreasing serum calcium thereby increasing sodium conduction across the nerve cell membranes and driving them towards depolarization." He says, further, that [the Appellant] was "describing an increase in rostral reticular potentiation increasing postsynaptic relays to the cerebral cortex and resulting in a decreased ability to sleep."

[Appellant's chiropractor #2] goes on to describe, at length, the fact that [the Appellant] was having trouble with her lower left leg, and attributes all of her symptoms to her motor vehicle injury of April 5th, 1995. He reports that [the Appellant] had seen her physician "who had recommended the use of ultrasound to kill the nerve endings in the ankle region" so that she would feel no pain. *(This statement, which is reiterated in later reports by [Appellant's*

chiropractic neurologist #1], is not supported by the evidence of [the Appellant] nor of her physician, [Appellant's doctor #1], but in any event was not a treatment that was pursued.) [Appellant's chiropractor #2] goes on to say that "treatment rendered in our office is the only treatment that has rendered [the Appellant] any form of continuous and gradual improvement." It will be noted from the evidence of [the Appellant] that this was not, apparently, a view that she shared. [Appellant's chiropractor #2] was conservatively estimating a further six months of further treatment, since even he agreed that she had not yet attained pre-accident status. From all the evidence, including that of [Appellant's chiropractor #2] himself, and despite his reports of improvement, the Appellant appears to have been regressing rather than progressing. At best, she was obtaining short-term relief during the creation of dependency.

(MPIC then made arrangements for [the Appellant] to have an independent chiropractic examination by [independent chiropractor], who saw her on September 16th, 1996. Reference to his report will appear later in these Reasons.)

November 19th, 1996: Having received from MPIC a copy of the report prepared by [independent chiropractor], and having been asked for additional information, [Appellant's chiropractor #2] rendered a further report to MPIC. That report is lengthy and consists, in the main, of a substantial exercise in physiology from a chiropractor's viewpoint, followed by [Appellant's chiropractor #2's] responses to a number of the comments made by [independent chiropractor]. In essence, [Appellant's chiropractor #2] explains why, in his view, [the Appellant] had not reached maximum therapeutic benefit and that ongoing chiropractic care is, indeed, indicated. He reiterates his conviction that [the Appellant's] ongoing symptoms are secondary to her motor vehicle accident.

May 7th, 1998: At this point, [Appellant's chiropractor #2] is referring [the Appellant] to [Appellant's chiropractic neurologist #1], in [Texas], and sends her copies of his reports to MPIC

of May 27th, 1996, and November 19th, 1996. He adds that he has "supplemented oxygen office with rehab, and at home, while monitoring with pH strips. She has attempted Mitochrondrial Resuscitate, and I believe she is currently using Co-Q10 to help assist in the oxidative phosphorylization process."

[Appellant's chiropractor #2] also tells [Appellant's chiropractic neurologist #1] that [the Appellant] has seen a surgeon "who has agreed that her ankle injuries are accident related but cannot provide any beneficial treatment. He recommends staying with our treatment, as it is the only thing that helps." *(We are obliged to note, in passing, that the surgeon to whom [Appellant's chiropractor #2] refers is a [Appellant's plastic surgeon] who, contrary to [Appellant's chiropractor #2's] letter, says only that "it is <u>possible</u> that this type of problem…<u>can</u> be related to an injury that <u>can</u> arise from a motor vehicle accident." Nowhere does [Appellant's plastic surgeon] recommend staying with [Appellant's chiropractor #2's] treatment.)*

September 23rd, 1999: [Appellant's chiropractor #2's] office renders an account to [the Appellant's] attorney, to cover the 144 chiropractic treatments given to [the Appellant] since April 30th, 1997, when MPIC had ceased paying for her chiropractic care. Almost all of those treatments were given between May 1st, 1997, and September 3rd, 1998—an average of 9.6 times per month.

EVIDENCE OF [INDEPENDENT CHIROPRACTOR]:

As noted above, [independent chiropractor] examined [the Appellant] on September 16th, 1996, at the request of MPIC. It is fair to say that [independent chiropractor], although not in the employ of MPIC, has performed a great many chiropractic assessments for that corporation.

In taking a history from the Appellant, [independent chiropractor] notes, in part, that, upon impact, she was jolted back and forward; when questioned about bodily contact, she thought that she hit her left leg underneath the dashboard. No other bodily contact was made, and at no time did she lose consciousness. She was able to exit from her vehicle without assistance. After going to [hospital] and being X-rayed and sent home, [the Appellant] had seen [Appellant's chiropractor #1] where she began treatments initially at three visits per week. She had subsequently switched over to [Appellant's chiropractor #2] and had continued treatments three times per week until the date of [independent chiropractor's] examination. She had not consulted with any other doctors. Her treatments from [Appellant's chiropractor #2] had consisted of spinal adjustments, occasional muscle stimulation, and the use of a foot orthosis which she had been wearing all the time, even when sleeping, since January 3rd, 1996. She had used a heart monitor for the previous three months and wore that permanently because, she said, it has been prescribed by [Appellant's chiropractor #2] who had also told her that she had oxygen deprivation; it was upon his advice that she had, therefore, been using an oxygen tank both at work and at home, and had been doing so for the past number of months. Her neck was much improved; her headaches had decreased in frequency and intensity, although she still had them on a daily basis. They were accompanied by occasional nausea. Her upper and middle back regions were also much improved and no longer sore; they had been fairly stable for the preceding few months.

[The Appellant] is reported to have told [independent chiropractor] that, although her lower back was improved, she always had pain to some degree in that region. Chiropractic adjustments provided temporary relief from a few hours to a day or so. Her left leg still swelled and gave her constant pain, although it, too, had improved. The pain was along the top of her ankle and above

the inside of her ankle (medial malleolus). Until she had been prescribed the brace, her entire leg would swell upward toward the knee.

[Independent chiropractor] also notes [the Appellant's] statement that she was able to perform all duties at work and at home, although she avoided lifting. [The Appellant's] primary problem seems, clearly, to have centred around her left ankle. [Independent chiropractor] reports that, on inspection, non-specific very mild swelling was noted above the left medial malleolus, but she had no evidence of any pitting edema. She was tender to palpation of the soft tissue structures above the medial malleolus and, as well, along the left tibial shaft, especially 14 cm. caudal to the tibial tubercle. Inversion and eversion of the left ankle evoked pain in her tibia and above the medial malleolus. Neurologically, [independent chiropractor] reported, no sensory deficits were detected. Radiological examination of [the Appellant's] left tibia and fibula disclosed no abnormalities.

[Independent chiropractor's] assessment and opinion may be summarized this way: [the Appellant's] motor vehicle accident had involved apparent low-velocity acceleration-type forces; she had sustained no fractures nor any dislocations and he had not been able to find any suggestion of direct nerve root compression relative to a spine-related disorder. Her main problem related to her left leg and, while she might have sustained a strain from bumping it, her prolonged symptoms were difficult to explain, aside from some form of unrelated peripheral neuropathy, whose etiology remained unknown. He could not explain her leg symptoms by referring them to her MVA. Lateral impact to the knee area could sometimes result in common peroneal nerve injuries, but [the Appellant's] findings on examination were not consistent with that type of problem. [Appellant's chiropractor #1], the chiropractor who first attended to her, makes no mention of any injury to her left leg. Her symptoms related to her left leg were not

spine related nor, in [independent chiropractor's] view, accident related. "As for the use of oxygen therapy along with her use of a heart monitor, I am at a total loss as to why these are being utilized. Their usage is highly questionable and I would question the therapeutic necessity as it relates to her accident claim. She has disuse atrophy of the left calf muscle and without a specific diagnosis I would question the use of her foot orthosis."

[Independent chiropractor] felt that [the Appellant] had long since reached maximum therapeutic benefit with chiropractic care and that ongoing treatment was not indicated. He suggested that she should see an orthopedic surgeon, a sports medicine specialist, or a neurologist and, as well, obtain the services of a general practitioner for a complete physical examination. He did not believe she was disabled, and he could detect no evidence of any permanent spinal impairment.

EVIDENCE OF [MPIC'S CHIROPRACTOR #2]:

[MPIC's chiropractor #2] is a chiropractic consultant with MPIC's Claims Services Department. He prepared a memorandum on March 14th, 1997. [MPIC's chiropractor #2] comments that [Appellant's chiropractor #2] "has offered a highly theoretic rationale supporting his ongoing chiropractic care…far from the mainstream of chiropractic theory and care." He notes, also, that [the Appellant] had had significant prior treatment with her former chiropractor. Treatment up to October 1996 was of a high frequency, at about 15 times per month, with no signs of decrease with the passage of time. [MPIC's chiropractor #2] refers to the Clinical Guidelines for Chiropractic Practice in Canada (1993) which state clearly that "progressively declining frequency is expected until discharge of the patient, or conversion to elective care." Those same guidelines contain the following statement:

> *Achievement of maximum therapeutic benefit: It is expected that patients will reach their maximum therapeutic benefit within six to 16 weeks. To minimize the development of physician/patient dependence, treatment frequency should not exceed two visits per week*

> *after the first six weeks…Should pre-episode status not return, or additional improvement not be forthcoming, maximum therapeutic benefit should be considered to have been reached.*

[MPIC's chiropractor #2] expresses the view that further treatment should not be considered with respect to [the Appellant's] motor vehicle accident.

(It should, perhaps, be noted that [MPIC's chiropractor #2] conducted a so-called 'paper review,' without any physical examination of the Appellant.)

EVIDENCE OF [MPIC'S CHIROPRACTOR #1]:

[MPIC's chiropractor #1] is also a chiropractic consultant to MPIC's Claims Services Department. On August 26th, 1997, he reviewed the entire contents of [the Appellant's] file, as it existed to that date. [MPIC's chiropractor #1] also had the benefit of examining MPIC's records related to [the Appellant's] accident of April 1993, when she was knocked off her bicycle by use of a motor vehicle. He notes that "records indicate that she was treated by [Appellant's doctor #2], who referred her for physiotherapy. The patient's chief complaints were <u>left ankle pain</u> and soft tissue injuries to both her neck and back." Quoting that portion of [Appellant's chiropractor #2's] February 13th, 1996, report (he erroneously attributes it to the October 30th, 1995, report) to which we have referred earlier on page 11 of these Reasons, [MPIC's chiropractor #1] says:

> I interpret this section to mean that the patient has had a traumatic accident which caused neck and back mechanical joint problems. These mechanical problems caused her brain thalamus to dysfunction, causing her ankle to become moderately to severely sore. These conclusions are unscientific and not consistent with current theory.

[MPIC's chiropractor #1] then quotes that portion of [Appellant's chiropractor #2's] October 30th, 1995, report to which we, also, have made reference on page 10 of these Reasons, and comments:

> My best interpretation of this is that [Appellant's chiropractor #2] feels the ligaments that have been damaged in the cervical, thoracic, and lumbosacral spine cause a reduction in neural input to the brain. This causes the brain to cause chronic and severe pain to the lower left limb. (These conclusions are unscientific, unsubstantiated, not reproducible, and not consistent with current theory which is taught at accredited colleges.)

[MPIC's chiropractor #1] adds that [Appellant's chiropractor #2] had continued to treat this patient 13 to 14 times a month for the next nine months, backed up solely by the foregoing theories. Neither the [hospital] nor [Appellant's chiropractor #1] had felt it necessary to examine [the Appellant's] foot radiographically, leading [MPIC's chiropractor #1] to believe that her leg was not an immediate concern after the accident. [MPIC's chiropractor #1] goes on to say that, despite [Appellant's chiropractor #2's] provision of great neurophysiological detail explaining why [the Appellant] had left leg pain and feels poorly, [Appellant's chiropractor #2's] reasoning and conclusions are not consistent with those taught in accredited chiropractic or medical colleges. "He is using unproven and unorthodox explanations and, from that, draws conclusions to treat patients which are not consistent with current chiropractic thought. The current scientific literature does not in any way support a relationship between the neuropathologic lesions as described above and the motor vehicle injuries." [MPIC's chiropractor #1] is of the view that [Appellant's chiropractor #2's] chiropractic care has clearly been shown not to alter the patient's symptom expression and is based on unorthodox methodology and outcomes. [MPIC's chiropractor #1] supported [independent chiropractor's] view and recommended that [the Appellant] see her medical physician for a neurological consultation.

INTERNAL REVIEW DECISION:

Meanwhile, based primarily upon [independent chiropractor's] opinion, MPIC's adjuster in charge of [the Appellant's] claim had written to her on April 4th, 1997, terminating payment for any further chiropractic treatment past April 30th. [The Appellant] had filed an application for a review of that decision on May 26th, 1997, and, on September 30th, 1997, MPIC's Acting Review

Officer adopted the opinions of [independent chiropractor] and [MPIC's chiropractor #1] and confirmed the adjuster's decision. She suggested that [the Appellant] see her medical doctor for a neurological consultation with respect to her leg.

[The Appellant] filed an appeal to this Commission on November 30th, 1997.

EVIDENCE OF [APPELLANT'S DOCTOR #1]:

In response to a letter of enquiry from this Commission, [Appellant's doctor #1], in a report March 2nd, 2000, indicates that [the Appellant] first consulted her on October 10th, 1997, with complaints of left ankle pain. She had told [Appellant's doctor #1] that she had injured the same ankle in a motor vehicle accident two years previously. Her car had been rear-ended, and she noted pain in the left ankle immediately after impact. She also experienced some neck and back pain which had resolved. [the Appellant] had described her pain as being mainly in the anteromedial lower leg and medial ankle. The pain impaired her function by causing her to limp at times. Treatment of her ankle to that date had included mainly a strengthening program, but [the Appellant] had felt that strengthening exercises made her pain worse and increased the swelling in her left ankle.

On physical examination there was a mild swelling over the medial malleolus. There was full range of motion of the left ankle, and the ligaments were intact. Movement of the subtalar joint was normal, but there was some tenderness on palpation around the ankle joint. Since common therapy techniques often offered by a family physician had already been tried, [Appellant's doctor #1] elected to refer [the Appellant] to [Appellant's sports medicine specialist] who apparently arranged for a magnetic resonance imaging and arranged for [the Appellant] to be seen by [Appellant's plastic surgeon]. [Appellant's plastic surgeon] had recommended no

surgical procedure. Since [the Appellant] had said she was still unclear how she should proceed, [Appellant's doctor #1] had arranged for a second opinion to be obtained from [Appellant's doctor #3], by way of an examination to take place on May 4th, 1998. In fact, [the Appellant] had never kept that appointment but, instead, had arranged to see a chiropractic neurologist in [text deleted], Texas. [Appellant's doctor #1] was not made aware of that change in plans until, on June 1st, 1998, [the Appellant] advised her that she had arranged to see [Appellant's doctor #4] at the Pan Am Clinic later in June. *(It was not made clear to us whether [the Appellant] ever did see [Appellant's doctor #4]; from the absence of any further mention of him in the evidence, we assume she did not.)*

[Appellant's doctor #1] had next seen [the Appellant] on September 23rd, 1998, to be told that [the Appellant] was still seeing the chiropractor in Texas and had had another MRI performed, which had revealed a C5-C6 disc protrusion. [Appellant's doctor #1] had commented that she was unsure why an MRI had been performed of the Appellant's cervical spine and that she ([Appellant's doctor #1]) would not pursue the finding of the disc protrusion, especially since [the Appellant] had no symptoms in that dermatome or myotome. [The Appellant] had said that she was continuing to see the chiropractor in Texas who was then going to try some 'magnet therapy.' [The Appellant] was unwilling to pursue the medical therapy recommended by [Appellant's doctor #1], who had not seen [the Appellant] since September 23rd, 1998.

EVIDENCE OF [APPELLANT'S SPORTS MEDICINE SPECIALIST]:

[Text deleted], a specialist in sports medicine, is a part-time member of MPIC's Medical Services team but, in this context, was acting as a private consultant in a referral from [Appellant's doctor #1]. [Appellant's sports medicine specialist], in a report to this Commission on February 16th, 2000, indicated that he had initially examined [the Appellant] on October 22nd,

1997. She had presented with problems involving her neck, back and left ankle, which she attributed to her 1995 MVA. She had said that the symptoms involving her neck and back were not significant but that the major problem involved her left ankle. A variety of treatments had not resolved the problem with her ankle; X-rays had all come back normal; any exercise program gave her pain and swelling, mostly involving the ankle as well as the distal medial aspect of her shin.

In describing the mechanics of her MVA, [the Appellant] is reported to have said that, at the time of the collision, her right foot was on the brake and her left foot on the floorboard. She apparently made no mention of an impact of her leg or ankle with any part of the car. The day after the collision, she said, she experienced pain and swelling around the ankle but did not note any bruising.

[Appellant's sports medicine specialist's] examination of [the Appellant's] legs had revealed soft tissue swelling over the medial distal aspect of her shin. That region was tender to palpation and had the feeling of a swollen bursa. Examination of the ankle was unremarkable, and no abnormalities were noted with respect to the subtalar joint. [The Appellant's] Achilles tendon was normal. [Appellant's sports medicine specialist] had ordered an MRI scan which had identified the abnormal area as asymmetric fat. There was no evidence to suggest a fascial defect, nor any more sinister type of soft tissue tumour.

[Appellant's sports medicine specialist] reviewed the MRI scan results with [the Appellant] on January 19th, 1998, when she said that her condition was unchanged. He, therefore, referred her to [Appellant's plastic surgeon] to determine whether surgical exploration might be helpful in identifying the problem and, possibly, resolving [the Appellant's] symptoms.

[Appellant's sports medicine specialist] concluded that [the Appellant's] soft tissue abnormality involving her left lower leg was that of a fatty deposit within the soft tissue structures. He could find no evidence to suggest a fascial herniation, nor any injury to the underlying musculotendinous structures.

[Appellant's sports medicine specialist] ends his report by saying:

> The exact etiology of [the Appellant's] pain was not identified. It was [the Appellant's] opinion that the abnormality she was assessed for developed as a result of the motor vehicle collision in question. Since my examination of [the Appellant] did not take place for over two years following the motor vehicle collision, I am uncertain as to how the fatty deposit identified on the MRI relates to the collision in question.

[Appellant's sports medicine specialist] had advised [the Appellant] to continue with home exercises which, he assumed, would include a stretching and strengthening program.

EVIDENCE OF [APPELLANT'S PLASTIC SURGEON]:

[Appellant's plastic surgeon], who has been referred to earlier in these Reasons, saw [the Appellant] on March 10th, 1998. Her main complaint was the persistent swelling on the medial aspect of her left leg, just near the ankle. [The Appellant] reported that the swelling had been present since the time of her MVA on April 5th, 1995, and was associated with pain radiating up the leg to the region of the knee. She found it difficult to walk and to do any form of physical or recreational activity because of that pain.

[Appellant's plastic surgeon's] clinical examination showed swelling on the medial aspect of the left lower leg, measuring about 8.0 cm. in diameter. It was tender to light touch, was soft and mobile, but was not a very discrete mass. No other abnormalities were detected. The area of swelling corresponded to a focal prominence of fat on the medial aspect of the left

lower leg. There was no evidence of a fascial defect in the region with the leg at rest. [Appellant's plastic surgeon's] report notes that "the etiology of the soft tissue mass and pain is unclear. Certainly from soft tissue injuries you can get this type of neuralgic type of pain. Perhaps it could be from irritation of underlying sensory nerves or weakening of the deep muscle fascia. It is possible that this type of problem with her left lower extremity can be related to an injury that can arise from a motor vehicle accident."

[Appellant's plastic surgeon] had explained to [the Appellant] that surgical intervention would not be beneficial and that the problem should be treated symptomatically.

EVIDENCE OF [APPELLANT'S CHIROPRACTIC NEUROLOGIST #1]:

[Appellant's chiropractic neurologist #1] is the chiropractic neurologist, practising in [text deleted], Texas, to whom [the Appellant] was referred by [Appellant's chiropractor #2]. We have had the benefit of many reports prepared by [Appellant's chiropractic neurologist #1]. Accepting the risk of serious oversimplification, we believe that we may fairly summarize the findings of [Appellant's chiropractic neurologist #1] and the treatments that she prescribed for [the Appellant] this way:

May 11th, 1998: [Appellant's chiropractic neurologist #1] assesses [the Appellant] with post-traumatic cervical joint breakdown/degradation, cervical and shoulder myospasms, decreased shoulder/rib mechanics and hyperventilation, cardiac dysfunction secondary to alteration of cervical cord reflexes, and "elevated sympathetic tone compromising peripheral vascular delivery (primarily left)." She prescribes therapy in the form of manipulative procedures which, on May 11th, result in:

- immediate resolution of headache

- "decrease in left sided blood pressure, so BP was 120/80 bilaterally." *(We find the word 'decrease' confusing, since [Appellant's chiropractic neurologist #1's] initial examination had shown elevated blood pressure on the left 120/80 and on the right 100/80.)*
- radial pulses reduced from 78 to 72 BPM, and now regular rather than the formerly irregular pulse
- respiration rate reduced from 24 shallow breaths per minute to 18 deeper ones
- pulse oximetry measured tissue saturation of oxygen as 99% in the fingers and 98% in the toes, bilaterally, as opposed to an initial measurement of 98% in the fingers, 84% in the left toes and 98% in the right toes
- an absence of bilateral, upper extremity claudication that had been found on initial examination
- hands and feet were warm and dry, no longer moist, clammy or cold
- no more swelling of the left ankle
- resolution of a left carotid bruit that had been audible on examination
- resolution of dry, red, scaly skin that had been noted behind [the Appellant's] left ear
- resolution of a left exophoria *(i.e., a tendency of the eye to move outwards)* that had been present on examination
- what is described as "residual decomposition left medial rectus after left lateral gaze"
- improved left lower facial and left palatal paresis—not resolved
- resolution of cervical/shoulder myospasms and paraspinal myospasms
- left ankle/lower leg pain unresolved
- left-sided headache returned after few hours

May 11th to 23rd, 1998: During this period, [Appellant's chiropractic neurologist #1] prescribed and, presumably, administered what are described as "manipulative therapeutics specific to [the Appellant's] decrease in cortical hemisphericity and specific to increasing rib and shoulder mechanics, increasing joint position sense and stabilization of post-traumatic cervical joint degradation." She also prescribed some exercise rehabilitation, oxygen at a rate of four litres per minute, with a mask to conserve CO_2 and simultaneously increasing oxygen necessary for muscle and nerve cell metabolism, plus specific brain-based exercises to increase activation of the left cortical hemisphere activity of the brain in order to increase modulation of muscle tone, sympathetic tone, heart rate and rhythm, respiration, sleep, mental cognition and concentration. As a result of all of these modalities, [Appellant's chiropractic neurologist #1] was able to report that, by May 23rd, [the Appellant's] neck pain, upper and low back pains, cervical, shoulder and paraspinal muscle spasms, motor weakness in her left upper and lower extremity, hypertonic muscles of the shoulders, arms, hips, legs and ankles had all been resolved, improvement had been achieved in cranial nerve-based deficits related to areas of the brain stem that also controls sympathetic tone, heart rate and rhythm, respiration, sleep, pain control, etc., and improvement in the degree of left-sided headache being experienced by [the Appellant]. [Appellant's chiropractic neurologist #1] notes that [the Appellant's] left lower leg/ankle pain was still unresolved. However, her peripheral vascular circulation and muscle tone had improved, although with continuing pain on the left side. [the Appellant] continued to hyperventilate and this, for unexplained reasons, was an apparent cause of continued pain. Continued cardiac abnormalities on EKGs were also noted, with a wide variety of findings—not consistent and apparently related to hyperventilation and residual central nervous system (brain-based) modulation of heart rate and rhythm. [Appellant's chiropractic neurologist #1] reports episodes of obvious depression and mood change. She recommends a return to [Manitoba] with specific instructions on physical exercise and "brain-based" exercises, with continued manipulative

therapeutics but a warning of the necessity of bringing [the Appellant's] continued hyperventilation under control. She records her expectation that, as joint mechanics stabilize and muscle spasms were stopped, the hyperventilation would be reversed.

June to August 1998: [the Appellant] reports the return of severe neck pain, tension in neck muscles, severe low back pain, increased severity of left-sided headache and of left leg/ankle pain, increase in loss of sleep, increase in nausea, increase in vomiting after eating anything, and eating and sleeping very little. [Appellant's chiropractic neurologist #1] recommends that [the Appellant] consult her medical doctor for medication to address apparent migraines and sleep loss, which was apparently done without noticeable result. Meanwhile, [the Appellant] continues to work, to attend [Appellant's chiropractor #2] two or three times weekly, and to complain of worsening symptoms. [Appellant's chiropractic neurologist #1], therefore, arranged for a consultation and a neurological evaluation of [the Appellant] with [text deleted], another neurological chiropractor, in [text deleted], Texas, in August 1998, at which [Appellant's chiropractic neurologist #1] and [Appellant's chiropractor #2] were also present. [Appellant's chiropractic neurologist #2's] findings are described by [Appellant's chiropractic neurologist #1] thus:

i) Right brain "escape" or over-activity needed to be addressed before left brain decrease in function.

ii) Right cervical cord compression had developed from enlarged veins secondary to increase in sympathetic tone and constricted arteries.

iii) Low RBC count (anemia); decreased oxygen carrying capacity.

iv) Hyperventilation and tachychardia: right brain based and limbic (emotional).

[Appellant's chiropractic neurologist #1] explains [Appellant's chiropractic neurologist #2's] diagnosis, in part, by commenting that the right cervical cord compression was probably secondary to post-traumatic sympathetic response and elevated blood pressure,

> or post-traumatic disc compression of the cervical cord affecting the most lateral nerve fibres on the right which transmit nerve impulses are from the left lower extremity in spinal cord columns that send information from the left side of the body to the left cerebellum so that a dampening of left cerebellar-right cortical integration developed affecting right brain control of vital centres including respiration, heart rate/rhythm, increased left-sided blood pressure or arterial constriction and giving rise to the left-sided headache and lower leg pain and swelling. *(The foregoing is an exact quotation.)*

[Appellant's chiropractic neurologist #2] felt that [the Appellant's] right foot extensor toe sign was indicative of right cervical cord compression. [Appellant's chiropractic neurologist #1] goes on to explain that:

> Left cortical decrease in synaptic integration has also occurred secondary to the decrease in joint position sense and kinesthetic potentiation from the right cervical cord, however, [Appellant's chiropractic neurologist #2's] evaluation demonstrated that her continued pain pattern and autonomic concomitants were more likely as a result of the effects of right cord compression on left cerebellar-right brain integration.
>
> The type of pain she has is complication and maintained by an increase in circulating catecholamines from the increase in sympathetic tone hyperventilation ("worst type of hypoxia").
>
> *(The foregoing is, also, an exact quotation.)*

With the declared goals of decreasing right-brain "escape," increasing left-brain integrity, controlling sympathetic tone and vascular compromise of the cervical cord and peripheral circulation, reversing the effect of circulating catecholamines and stabilizing mechanical dysfunction of the neck, shoulder and rib joints, [Appellant's chiropractic neurologist #2] prescribed 'right-brain specific exercises,' including:

a) looking at anonymous, smiling faces;

b) prosaic verses/nursery rhymes, laughter, calming/relaxing music;

c) a blinder to decrease left visual stimulation to the right brain; and

d) rose-coloured lenses to decrease the amount of activation of high brain stem (mesencephalon) to aid in decreasing sympathetic tone.

(We pause here to note that the foregoing recommendation for a blinder to decrease left visual stimulation seems to be at odds with subsequent advice given by [Appellant's chiropractic neurologist #1] to "use a hemifield visual stimulatory videotape with ([the Appellant's]) right eye covered for five-minute intervals if helpful.")

August to September 1998: After returning to Canada, remaining under the care of [Appellant's chiropractor #2] and returning to full-time work, [the Appellant] complained of continuously worsening symptoms, was medically diagnosed with clinical depression but refused all medication prescribed for her, and returned to [Texas] on September 4th, 1998.

September 4th to 14th, 1998: Having returned to [Appellant's chiropractic neurologist #1's] clinic in [Texas], with the same symptoms as before, [the Appellant] was again examined. Included in that examination was another magnetic resonance imaging of her cervical spine which reportedly showed a 3 mm. posterocentral disc protrusion at C5-C6 which was minimally contacting, but not displacing, the spinal cord. There was also minimal disc bulging at C6-C7. [Appellant's chiropractic neurologist #1's] clinical assessment was of right cervical cord compression (vascular, not disc related), anterior cervical cord compression (disc related), left cerebellar hypometabolism, increased sympathetic tone, and hyperventilation. There followed "extensive one-on-one with the patient from trained staff members with therapy including two cycles per hour of 20 minutes of holding up happy, serene, anonymous faces" for [the Appellant] to observe—a therapy that was repeated all day, every day—, rose-tinted glasses which were worn constantly during the day, breathing exercises, and, for the first three or four days, manipulative therapy. The reported results were little short of miraculous: joint dysfunction in [the Appellant's] neck, shoulders, ribs and low back were resolved, muscle spasms and neurological deficits were resolved, physical and neurological integrity were greatly improved, pain was decreased, blood pressure was lowered and circulation improved, right cervical cord compression was resolved, [the Appellant] was able to sleep for six hours during at least a couple

of nights and at least three or four hours at other times, she was able to eat without vomiting, and her neck and back pain were resolved. The only remaining problems appear to have been the continuance of her left headache and left leg pain, which [Appellant's chiropractic neurologist #1] ascribed to "respiratory dysfunction of fast, shallow breathing and the increase in sympathetic tone."

September 1998 to January 1999: Having returned home on September 15th, 1998, with instructions to avoid further chiropractic manipulation and massages, but to follow a regimen of prescribed physical exercises and other modalities, [the Appellant] reported that, although she was compliant with all of [Appellant's chiropractic neurologist #1's] instructions, she had continued to work full-time and her symptoms had all returned and worsened. On the advice of [Appellant's chiropractic neurologist #1], [the Appellant] therefore made plans to spend two full, consecutive months attending [Appellant's chiropractic neurologist #1's] clinic in [Texas], where she went on January 19th, 1999.

January 19th to July 6th, 1999: [the Appellant] is reported to have arrived at the [text deleted] clinic on the afternoon of January 19th, almost immediately after reaching [Texas]. She complained of left-sided headache, very severe and "way over a level 10" (10 being the maximum on a scale of zero to 10), a severe left lower leg and foot pain, also above maximum level, severe nausea having, she said, eaten nothing for two whole days due to nausea and vomiting, not sleeping more than one hour per night *(despite apparently having driven from [Manitoba] to [Texas])*, severe neck, upper and lower back pain, also severe and at level 10. After another examination, from which [Appellant's chiropractic neurologist #1] found increased hyperventilation, increased circulating catecholamines, increased peripheral vascular compromise, right extensor toe indicative of residual right cervical cord compression, increased depression but general physical improvement despite residual joint instabilities. [Appellant's chiropractic neurologist #1] prescribed a variety of therapies to be performed in regular cycles,

all day and every day, including (but not limited to) relaxing piano or harp music during all "exercises," lullabies during rest times, anonymous happy, serene faces for 20 minutes at a time, rhythmic nursery rhymes for similar periods, funny movies for laughter during lunchtime, lukewarm whirlpool for 20 to 30 minutes at a time with colours added to the water, aromatherapy, counting backwards by sevens or nines to slow respiration and settle nausea, abdominal breathing exercises, and, with the passage of time and musculoligamentous improvement, some physical exercises such as cervical traction and corner pushups. Vibratory deep massage apparatus was applied to posterior shoulder and lateral hip joints, alcohol sponge baths were applied to decrease pain in the shoulder, neck, back, legs and foot muscles. A dietary regimen was prescribed, along with chiropractic manipulations.

In consequence of the foregoing, [Appellant's chiropractic neurologist #1] was able to report the resolution of all neurological deficits (motor tone, extraocular decomposition of movements and pathological ocular functions, cranial nerve deficits, and right extensor toe sign), resolution of neck and back pain, improved peripheral vascular delivery, improved posture, improved gait, and improved mental affect. She reports, however, that [the Appellant] had residual leftsided headache, painful lower legs, poor sleep, hyperventilation, depression, and a tendency to vomit after eating. [Appellant's chiropractic neurologist #1's] prognosis was "good but guarded." [The Appellant] was sent home to [Manitoba] with instructions to continue much the same daily regimen that had been followed at [Texas], but omitting any further chiropractic manipulations and adding exercises to stretch and strengthen posterior shoulder muscles by hanging from a door and doing corner pushups combined with deep-breathing exercises. She was instructed to continue "home exercises to ensure cortical/brain plasticity continued to increase central nervous system regulation." [Appellant's chiropractic neurologist #1] also recommended further

consultation with [text deleted], psychiatrist, being of the view that medication and counselling for depression were probably necessary.

[Appellant's chiropractic neurologist #1] also testified by way of telephone conference call, primarily to confirm certain portions of her numerous, written reports. When the Commission asked her how it was that she had been able to accomplish, in a space of about 10 days, what [Appellant's chiropractor #2] had been unable to achieve in three and one-half years using treatment modalities that, at least in the context of chiropractic manipulation, seemed to have been almost identical, [Appellant's chiropractic neurologist #1] modestly indicated that some practitioners are more experienced than others.

EVIDENCE OF [MPIC'S DOCTOR]:

[MPIC's doctor] is medical director of the insurer's Claims Services Department. It must be noted that he also has never met with [the Appellant] and that his views are based entirely upon examinations of the corporation's file respecting [the Appellant's] claim.

When the file was first referred to [MPIC's doctor] in June 1997, he offered a brief comment to [MPIC's chiropractor #2] that "some of the recent correspondence from [Appellant's chiropractor #2] details opinions which are somewhat controversial and, in fact, in my opinion, incorrect."

Two subsequent memoranda prepared by [MPIC's doctor] bear date September 2nd and November 9th, 1999. Conscious, again, of the risks of oversimplification inherent in a précis, we believe that [MPIC's doctor's] views may fairly be summarized this way:

- Clinical notes received from [Appellant's chiropractor #2] clearly indicate that [the Appellant] had pre-accident problems of a similar nature to those of which she complained after April 5th, 1995. The appellant's left ankle problems, overall pain, stress reactions, and difficulty with lactic acid myospasm had all existed prior to her 1995 MVA.
- Indeed, the available evidence related to [the Appellant's] 1993 accident indicated the need for the use of crutches and an inability by the appellant to bear weight on her left ankle, secondary to pain. There was a bruise over the right lateral malleolus of the ankle, and the left ankle was tender laterally over the anterolateral ligaments, as well as the metatarsals. [The Appellant] also sustained apparent injury in 1993 to her paracervical and paralumbar musculature.
- As of June 1st, 1993, [the Appellant] had been diagnosed with a reflex sympathetic dystrophy of the left foot and erythema of her great toe with ongoing discomfort. "Reflex sympathetic dystrophy can be referred to as causalgia, or a complex regional pain syndrome. It often has a poor prognosis with longstanding discomfort."
- The appellant had continuing symptoms respecting her left ankle, as well as her cervical and lumbar spine, for at least seven months after her 1993 accident according to the records of her family physician at the time. Thereafter, based on ongoing complaints that she voiced to [Appellant's chiropractor #2], she had not apparently recovered from any of those problems prior to the April 1995 accident.
- [Appellant's chiropractor #2's] first note related to the 1995 MVA, dated October 30th, 1995, had stated incorrectly that [the Appellant] had not encountered any disabling physical or mental limitations prior to her MVA and that [Appellant's chiropractor #2] had not treated her for prior, similar problems.

- Notwithstanding the highly theoretic nature of [Appellant's chiropractor #2's] pathophysiologic speculation, the information based on notes on file clearly indicated that the attribution of causation for the ankle problems to the 1995 motor vehicle accident was incorrect. [The Appellant] had documentation of left ankle problems associated with her activities of daily living prior to the MVA in question.
- The pathophysiologic mechanisms described by [Appellant's chiropractor #2] are not plausible, since they ante-dated the accident in question; the same comment, therefore, must necessarily apply to the mechanisms and the diagnoses described by [Appellant's chiropractic neurologist #1].
- [MPIC's doctor] expresses extreme concern that the theoretic pathophysiologic mechanisms contained in the chiropractic material on file had been presented as fact, validated and without question. He felt that any individual would probably become very anxious, and even depressed, on receiving information that their brain pathways had become abnormal, and that they had severe and refractory nerve problems, heart problems, and respiratory problems. He was of the view that the information on file was insufficient to have allowed such clinic assessments to be made.
- Not only was there definite evidence documented that [the Appellant's] left ankle complaints were pre-existing, and had actually been described as being exactly like those prior to the MVA, but [the Appellant] had attended her practitioner less than five weeks prior to the accident in question because of pain in the left ankle which was recurrent. He noted that this information had not been provided to MPIC by the Appellant.

EVIDENCE OF [APPELLANT'S REHAB SPECIALIST]:

[Text deleted] is a specialist in physical medicine and rehabilitation [text deleted]. She examined [the Appellant] at [text deleted] on November 24th, 1998, at the request of [the Appellant's] lawyer, [text deleted]. She noted a flat, non-smiling affect on the part of the Appellant; normal pupillary function; some tightness of the posterior cervical muscles, more so on the right than on the left. She found tightness of the trapezius muscle, more on the left than on the right. The scalene muscle was also tight, but none of those muscles had any active trigger points nor any referred pain to suggest active Myofascial Pain Syndrome. [The Appellant] had good mobility of her neck in all directions, except that lateral flexion to the right was slightly limited. There was flattening of the thoracic kyphosis, but no tenderness over the muscles around the thoracic spine, the chest muscles, or the shoulder girdle. There was some tenderness over the L5 and S1 facets bilaterally, and slight tenderness over the left gluteal muscle. There was tightness of the left hamstring and some swelling which was evidence of the old fat collection.

The remainder of [the Appellant's] musculoskeletal examination was within normal limits; she had normal gait. [Appellant's rehab specialist] found no evidence of any neurologic dysfunction in [the Appellant's] upper or lower limbs. (As [MPIC's doctor] points out in a recent memorandum of March 6th, 2000, the numerous neurologic findings described by [Appellant's chiropractor #2] and [Appellant's chiropractic neurologist #1] are inconsistent with the results of [Appellant's rehab specialist's] examination. [Appellant's rehab specialist] recommended that, since [the Appellant] had had three and one-half years of chiropractic manipulation at a frequency of three and four times per week, with no long-term resolution of her symptoms, she should seek some alternative treatment. In [Appellant's rehab specialist's] view, [the Appellant's] functional capacity allowed her to manage a job as an [text deleted]. Further chiropractic manipulation was contraindicated, particularly since, according to [Appellant's

chiropractor #2] and [Appellant's chiropractic neurologist #1], the Appellant had spinal instability.

[The Appellant] had told [Appellant's rehab specialist] that she had worn the orthotic device for her left shoe, recommended by [Appellant's chiropractor #2], for a year, but that it had not helped at all.

THE ISSUES:

Counsel for [the Appellant] correctly submits that there are three issues confronting this Commission

- Were the injuries of which [the Appellant] complained from April 1995 to October 1st, 1999, caused by, or directly related to, her motor vehicle accident of April 5th, 1995?
- Were the treatments, for which the Appellant now seeks reimbursement, appropriate? And
- Did the Appellant sustain injuries in her April 5th, 1995, MVA to an extent that required her to cease working, close her business and travel to [text deleted], Texas, in January 1999?

DISCUSSION:

We have felt it necessary to deal, at much greater length than might otherwise have been the case, with the medical and chiropractic evidence made available to us. We have dealt, particularly, with the evidence of [Appellant's chiropractor #2] and [Appellant's chiropractic neurologist #1], upon whose views [the Appellant's] claim rests almost entirely.

We start from the premise that, although we are well aware of the fact that the extent of damage to one or both vehicles in a collision does not necessarily indicate the extent of the trauma to the

bodies of their occupants, the MVA in which [the Appellant] was involved on April 5th, 1995, was, in fact, a very minor one. Her own vehicle sustained damage to the extent of $160, including parts and labour; the vehicle that struck hers was not damaged at all. We have great difficulty in accepting the proposition that an accident of that kind could have given rise to the extraordinary multiplicity of physical and emotional problems reflected in the evidence.

None of [the Appellant's] caregivers—not even [Appellant's chiropractor #2] and [Appellant's chiropractic neurologist #1]—was able to describe any actual injury to [the Appellant's] leg. If we correctly interpret their collective opinion, [Appellant's chiropractor #2] and [Appellant's chiropractic neurologist #1] seem to be telling us that the Appellant's leg pain was due to overall neurologic deficit or dysfunction although, it has to be said, none of the other practitioners who examined [the Appellant] was able to make the same finding. While [the Appellant] does seem to have had a mild, soft-tissue swelling on her left lower leg, it is quite clear from the MRI and other reports that this consisted of a collection of fat and was quite unrelated to her motor vehicle accident.

The only major factor favouring the position taken on behalf of [the Appellant] at the time of her hearing is that, if we concentrate solely upon her own testimony, she had been complaining about her neck, back and leg problems from Day One, immediately following her accident, and that, despite all of the physicians and chiropractors who had assessed and/or treated her, the simple fact was that it was only during her intensive treatment by [Appellant's chiropractic neurologist #1] that her problems were almost completely resolved. As noted earlier in these Reasons, [the Appellant] testified that she kept on working as long as she possibly could but was eventually driven from the workplace and forced to close her business (being unable to find one of her own workers or anyone else willing to manage the store during her intended sick leave and

unable to find a purchaser) because her multiple pains eventually rendered her incapable of working any longer. The very nature of her work involved several kinds of repetitious movement, with constant flexion of her neck and shoulder muscles. Supported by [Appellant's chiropractor #2] and [Appellant's chiropractic neurologist #1], she realized that she had to eliminate those kinds of repetitious motions completely, at least for a couple of months, if not longer, if she were going to recover.

Arrayed against that position, in no particular priority, are these factors:

1. Her original chiropractor, [text deleted] (who, [the Appellant] testified, had neither treated nor even seen her), reported that he had examined her on April 6th, the day after her accident, and that she had presented with a list of problems: "head and neck pain and stiffness with a moderate constant headache, mid-back pain, and sore, stiff muscles and joint." It is noteworthy that [Appellant's chiropractor #1's] report makes no mention of her lower left leg and ankle having been injured in her 1995 MVA. He felt she was capable of resuming her main occupation although her disability might continue for as long as a year. Notwithstanding his prescription of two or three adjustments per week for six weeks, [Appellant's chiropractor #1] said that the next appointment he made for [the Appellant] was for May 5th, 1995. It is not clear whether [Appellant's chiropractor #1] ever saw her again.
2. On October 30th, 1996, [Appellant's chiropractor #1] is reported to have advised MPIC's adjuster that [the Appellant] had "had lots of care from him since 1990, 1994-1995…lots of problems…treatment for really bad headaches not MVA-related, which are almost constant." [The Appellant] testified that almost all of her pre-MVA chiropractic treatments were for the activities of day-to-day living, whereas [Appellant's chiropractor

#1] emphasizes that they were primarily for severe headaches, unrelated to any motor vehicle accident.

3. [The Appellant] does not seem to have seen [Appellant's chiropractor #2] until August 3rd, 1995, with, as he puts it, "ongoing exacerbations of her symptoms resulting from the April 5, 1995, vehicle accident." She is reported to have told [Appellant's chiropractor #2] that she noticed immediate pain and swelling in her left ankle and localized pain in her low back at the time of the accident, as well as immediate burning and pulling sensations into the back of her neck. This is not in accord with the report of [Appellant's chiropractor #1] who is known to this Commission to err (if at all) on the side of unusual completeness.

4. A reading by [Appellant's chiropractic radiologist] in California of [the Appellant's] X-rays taken at [hospital] in [Manitoba] immediately following her accident notes only a minimal right convex curve; facet arthrosis at L4/S1; a thoracic spine well within all normal limits, although with a slight left to right curve; and a decrease in the range of motion of [the Appellant's] cervical spine, suggesting to [Appellant's chiropractic radiologist] the possibility of underlying paravertebral muscle spasm. We observe that these conditions are common in the general population.

5. The cost of repairing damage to both vehicles involved in this MVA amounted to some $160;

6. [Independent chiropractor], in his independent assessment, felt that [the Appellant] had "long since reached maximum therapeutic benefit with chiropractic care." As for her left leg symptoms, [independent chiropractor] felt she should see an orthopedic surgeon, a sports medicine specialist, or a neurologist. He found no signs suggestive of any nerve root compression. [Independent chiropractor] is the only person to whom [the Appellant] appears to have mentioned that she thought she had hit her left leg under the dashboard.

7. There is no mention of any left leg injury appearing from the hospital records at the time of the accident. [The Appellant] was X-rayed, given an anti-inflammatory analgesic tablet, and sent home.

8. The theory of [Appellant's chiropractor #2] and [Appellant's chiropractic neurologist #1] seems to be that, while she probably did not sustain any direct injury to her leg or ankle (and this is borne out by the evidence of [the Appellant] herself), the injury to her cervical spine has given rise to the pain in her ankle. Neither of them has been able to explain to our satisfaction why, even if that theory is valid, once the pain in the neck and upper back has been resolved the pain in the leg persists. It is, however, noteworthy that she sustained a serious injury to her leg in her 1993 accident and [the Appellant], on cross-examination by counsel for MPIC, acknowledged that she had been seeing [Appellant's chiropractor #2] "both before and after my 1995 accident. Before that accident, I had had ankle and leg problems from my 1993 accident and [Appellant's chiropractor #2] would adjust the ankle joint."

9. This Commission has serious doubts as to the efficacy or necessity of treatments supplied to this lady by [Appellant's chiropractor #2] and [Appellant's chiropractic neurologist #1]. [Appellant's chiropractor #2], who apparently studied the neurologic aspects of his profession, in whole or in part, under the guidance of [Appellant's chiropractic neurologist #1], does not seem to have done anything very different from that which [Appellant's chiropractic neurologist #1] did, if one sets aside for the moment the soft music, rose-coloured spectacles, happy anonymous faces, and other pacifying modalities employed by [Appellant's chiropractic neurologist #1]. The duration and frequency of chiropractic treatments received by [the Appellant] from [Appellant's chiropractor #2] are, in our respectful view, little short of astounding and certainly far beyond anything contemplated by the Clinical Guidelines for Chiropractic Practice in Canada, published as

a supplement to the Journal of the Canadian Chiropractic Association in March 1994 and adopted by the profession's association in Manitoba.

10. Putting aside the clinical theories of [Appellant's chiropractic neurologist #1] and [Appellant's chiropractic neurologist #2]—although serious doubts have been cast upon those theories by both medical and chiropractic practitioners in Manitoba—[Appellant's chiropractic neurologist #1's] reports raise some doubts as to their accuracy. For example, "…by this time she [the Appellant] was not sleeping at all and not eating due to vomiting all she ate." [Appellant's chiropractic neurologist #1] appears to accept as gospel much of the grossly exaggerated reports made to her by [the Appellant]. One example will serve to illustrate our concern in this context: [the Appellant], who is suffering from such a multiplicity of problems that she is obliged to close down her business and personally drive all the way from [Manitoba] to [Texas], reports that she had not slept more than one hour per night, had eaten nothing for two days due to nausea and vomiting, and has very severe pains, either at or above the maximum perceived level of "10" on the left side of her head, left lower leg and foot, neck, upper and low back. This latter report refers to [the Appellant's] arrival in [Texas] on January 19th, 1999. And yet, we are told that in the period from September 4th to 14th of 1998, within a period of 10 days, almost all of the multiple problems with which [the Appellant] had presented had been resolved by [Appellant's chiropractic neurologist #1's] care, save only the left leg and left headache pain which continued.

11. [Appellant's chiropractic neurologist #1's] report to [the Appellant's] counsel, dated May 20th, 1999, says, in part:

> The flexed posturing of [the Appellant's] neck all day while working as an [text deleted] created more cervical spasm, vascular profusion and severe compromise of chest and shoulder mechanics, consequently leading to a very severe drive toward glycolysis depleting mitochondrial stores of supporting muscles as well as mitochondrial stores of central neurons. Arterial constriction compromising

> peripheral vascular delivery and venous return, insufficient oxygenation and the compromise of cervical cord transmitted motor nerve impulses progressively led to more pain, more physical disability and finally to brain-based neurological deficits modulating pain, autonomic and motor pathways.

In a preceding paragraph, [Appellant's chiropractic neurologist #1] concludes that "trauma to joints of the cervical spine resulted in nociceptive reflex afferent myospasms and post-traumatic vascular profusion in and around the sites of injury pathologically affecting cervical cord reflexes and promoted joint degradation, more myospasm to the point of seizing up of rib and shoulder mechanics so that it was painful to walk or breathe." She goes on to conclude that vascular profusion in and around the sites of injury eventually led to vascular cord compression that became evident by August 1998. With deference, we are not able to find from the evidence before us that [the Appellant] sustained 'trauma to the joints of her cervical spine' of the magnitude contemplated by [Appellant's chiropractic neurologist #1], nor is there credible evidence that 'vascular profusion in and around the sites of injury eventually led to vascular cord compression' and became evident three and one-half years after the motor vehicle accident. The quoted portion from [Appellant's chiropractic neurologist #1's] May 20th, 1999, report that is inset above merely indicates that the stooping position in which [the Appellant] was obliged to work resulted in a constriction of her vascular system, a situation that presumably would have prevailed even in the absence of a motor vehicle accident. It surely could have been alleviated by frequent changes of position and appropriate stretching and extension exercises.

Counsel for [the Appellant] correctly points out that none of the other medical and paramedical professionals who examined or treated [the Appellant] was able to find the cause of, nor was any of them able to prescribe a cure for, the symptoms of which she

complained, and that only [Appellant's chiropractor #2] and [Appellant's chiropractic neurologist #1] pursued intensive treatment from which [the Appellant] believes she eventually obtained long-term relief. This is true and is a fact that we have considered most carefully. We also acknowledge that, just because, as [MPIC's doctor] puts it, "the pathophysiologic mechanisms described by [Appellant's chiropractic neurologist #1] are theoretic" does not necessarily mean that they are wrong. At the same time, those same pathophysiologic mechanisms originally described by [Appellant's chiropractor #2] and, in large measure, adopted by [Appellant's chiropractic neurologist #1] lose plausibility when considered against the backdrop of [the Appellant's] pre-accident condition; most, if not all, of those mechanisms pre-dated the April 1995 MVA.

12. In her report of March 2nd, 2000, [Appellant's doctor #1] says very clearly that, when [the Appellant] first consulted her on October 10th, 1997, with complaints of left ankle pain, "she also experienced some neck and back pain which had resolved. She described the pain as being mainly in the anteromedial lower leg and medial ankle." It is also noteworthy that, although [Appellant's doctor #1] had arranged for [the Appellant] to obtain a second opinion about her leg and ankle from [Appellant's doctor #3] on May 4th, 1998, the Appellant never kept that appointment, but, instead, headed for [Texas].

FINDINGS AND DISPOSITION:

Upon a careful review of all of the evidence presented to us, both written and oral, and of the submissions by counsel for each of the parties, we find that:

1. To the extent that any of [the Appellant's] injuries were related to her motor vehicle accident of April 5th, 1995, whether originating in that accident or merely an exacerbation of a pre-existing condition, their natural history would have brought about their

resolution long before January of 1999, when [the Appellant] closed her business and travelled to [Texas].

2. The extensive chiropractic treatments administered to [the Appellant] by [Appellant's chiropractor #2] (whom, according to [the Appellant's] evidence, she had been seeing approximately 10 times per month before her accident), over a period from August 3rd, 1995, to April 30th, 1997, were, in our respectful view, excessive in any event and, in the context of [the Appellant's] motor vehicle accident, probably both unnecessary and unhelpful beyond December 1996 at the latest. MPIC discontinued payments for chiropractic treatment as of April 30th, 1997, and we can find no justification for ordering the insurer to pay for the additional 144 treatments that [the Appellant] received from [Appellant's chiropractor #2] between April 30th, 1997, and September 16th, 1998, both inclusive.

3. By the same token, an order from the Commission that MPIC pay for [the Appellant's] chiropractic treatments in Texas, at a cost of $9,215, plus additional services such as X-rays, tests, CT scan and MRI plus supplies and equipment, for an additional $2,132.99—a grand total of US$11,247.99—cannot be justified, even if the Manitoba tariff were applied. Although we are not in a position to make a firm finding of fact on the point, it is at least strongly arguable that, had [the Appellant] simply elected to take several months off from her work in [Manitoba] in order to stay home, listen to some music and relax, she would have been able to return to work a lot sooner, particularly if she had accepted the advice given her by her psychiatrist and her family physician.

4. If, indeed, it became necessary for [the Appellant] to quit working in January of 1999, that necessity does not have its origins in her motor vehicle accident of April 1995.

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

Dated at Winnipeg this 31st day of March, 2000.

J. F. REEH TAYLOR, Q.C.

COLON SETTLE, Q.C.

LILA GOODSPEED