Automobile Injury Compensation Appeal Commission

IN THE MATTER OF an Appeal by [the Appellant]
AICAC File No.: AC-98-163

PANEL:	**Mr. J. F. Reeh Taylor, Q.C., Chairman** **Ms. Yvonne Tavares** **Mr. F. Les Cox**
APPEARANCES:	**The Appellant, [text deleted], was represented by [Appellant's representative];** **Manitoba Public Insurance Corporation ('MPIC') was represented by Ms. Joan McKelvey.**
HEARING DATE:	**November 28th, 2000**
ISSUE:	**Whether Appellant entitled to Income Replacement Indemnity ('IRI').**
RELEVANT SECTIONS:	**Sections 83(1), 84(1) and (2) of the MPIC Act and Sections 5 and 8 of Manitoba Regulation No. 37/94 (copies of these sections are annexed to these Reasons).**

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, age [text deleted] at the time, was driving her [text deleted] on March 2nd, 1997, when, stationary at a pedestrian crossing, it was rear-ended by a [text deleted]. The cover of her vehicle's rear bumper was pushed in evenly, causing approximately $500 worth of damage. Three days later, on March 5th, she attended upon her family physician, [text deleted], who diagnosed a Grade 1 Whiplash Associated Disorder and paracervical muscle strain. Her range of motion at the neck was restricted; she was advised by [Appellant's doctor #1] to rest and to apply heat.

She next saw [Appellant's doctor #1] on April 8th, still complaining of pain in her neck although her range of motion at the cervical spine was now full, albeit with some tenderness over the muscles of the upper back. She was referred by [Appellant's doctor #1] for physiotherapy, which she received twice weekly for the next 11 weeks at the [text deleted] Physiotherapy Clinic.

She next saw [Appellant's doctor #1] on June 25th, 1997, by which time her neck pain had improved but she was now complaining of upper and lower back pain. She had full range of motion of the cervical spine but [Appellant's doctor #1] noticed some trigger points over the right shoulder blade and lower dorsal muscle. [Appellant's doctor #1] advised the continuance of physiotherapy.

[The Appellant] next attended upon [Appellant's doctor #1] on September 12th, 1997, complaining of headaches. She reported that the headaches she had encountered after her motor vehicle accident ('MVA') had improved during the summer, since she had not been working after April 30th, 1997, but had now become worse since she had recommenced work at the beginning of September.

At the time of her accident, [the Appellant] testified, she was employed on a part-time basis as a Library Assistant II at [text deleted], working five hours per day, five days per week. Her employment would start in early September and, excluding the Christmas and mid-term breaks, would continue through April 30th, when she would be laid off in the ordinary course until the start of the following academic year. She testified that she also worked from 8 a.m. to 4 p.m. every Saturday at [text deleted] for 10-week sessions, although she was only paid to work from 9

a.m. until 12:30 p.m. Her wages at [text deleted] were $13.94 per hour; at [text deleted], $20 per hour.

While she continued working at [text deleted] from March 3rd until April 30th, 1997 (although, she said, with difficulty), she felt that she had to resign from her work at [text deleted] shortly after her accident, since she did not feel up to teaching the session that was to have started in April of 1997.

In late July and early August of 1997, [the Appellant] took a vacation, driving herself to [text deleted] and back although, she said, the pain had been too much to permit her enjoyment of that trip. Also, in mid-summer of 1997, having given notice to her landlord prior to her MVA in anticipation of a move to [text deleted] to join her boyfriend, she had to move in with her father, with whom she stayed for the next two years.

She started back to work at the beginning of September 1997, but encountered too much pain and, in consequence, apparently used up all of her sick time. Her supervisor suggested that she quit work on November 25th, 1997, and take time fully to recuperate, with a view to returning to work in September of the following year. In the meantime, a replacement was found to do her work from November 25th, 1997, through April 30th, 1998. In the ensuing months, [the Appellant] received Employment Insurance, followed by Social Assistance and disability benefits. She returned to work at [text deleted] in September of 1998.

[Appellant's doctor #1's] initial narrative report, bearing date December 31st, 1997, notes that [the Appellant] had a longstanding history of depression and had been seeing [text deleted], psychiatrist. [Appellant's doctor #1] advised her that her headaches could be tension headaches

and that she should check with [Appellant's psychiatrist #1] for reassessment of her antidepressant medication. [Appellant's doctor #1] was of the view that [the Appellant's] depression could have contributed to her problems. In the several visits paid by [the Appellant] to [Appellant's doctor #1] in October and November of 1997, [Appellant's doctor #1] reports that [the Appellant] "felt very relaxed except for pain in neck and back was unchanged. I could not find any physical signs of her pain in neck and back. Her physiotherapy was not helping so I have made an appointment with [Appellant's doctor #2] to assess her".

[The Appellant] filed an application for compensation with MPIC on November 19th, 1997, although, it must be added, [Appellant's doctor #1] had completed an initial health care report for the insurer on July 3rd of that year.

It was not until January 22nd, 1998, that [the Appellant's] Case Manager at MPIC wrote to tell her that, since there was no medical information to indicate that she was not capable of performing the duties of her pre-accident employment, no IRI would be paid.

A report from [text deleted] Physiotherapy to MPIC's Case Manager, dated February 5th, 1998, reflects that, initially, [the Appellant's] neck range of motion was quite good - about 80% of normal except on flexion to the right side which was 75% of normal. The Appellant had reported "sharp" trapezius pains with rotation and side flexions. Her range of motion had increased to near normal. [The Appellant] had reported that at times her neck felt "okay" and on other occasions her discomfort was "off and on". By July of 1998 [the Appellant] had begun increasing her activities to include gardening, watering plants, pulling weeds and also sewing. In consequence, the upper middle thoracic area had started giving her occasional sharp pain and, generally, became more sore. Physiotherapy treatments were directed to the T4-T6 area of her

spine and, said the physiotherapist, "worked well for relief". On September 12th, 1997, [the Appellant] had told her physiotherapist that she had returned to work and had noticed increased neck pain; her physician had felt that she should restart physiotherapy.

On February 16th, 1998, MPIC's Case Manager again wrote to [the Appellant] to deny her entitlement to IRI benefits, for the reason given on January 22nd.

A report of February 16th, 1998, prepared by [Appellant's doctor #2], indicates that he had first seen [the Appellant] on March 2nd, 1997. His report repeats that error elsewhere. In fact, that was the date of her accident; she was not referred to [Appellant's doctor #2] by [Appellant's doctor #1] until December 31st, and he did not see her until January 8th, 1998. At their first meeting, [Appellant's doctor #2] reports, [the Appellant] had complained of headaches, stiffness in the neck and neck pain, mid and low back pain, pain in the hips, pain radiating to the left leg up [*sic*] to the foot, cramping type of pain in the left leg and foot with sensations of pins and needles, locking of the temporomandibular joints off and on, and reduced functional capability with low endurance for any medium to heavy activity. She had told [Appellant's doctor #2] that, while physiotherapy had given her some degree of pain relief in the neck and back, her symptoms had never been fully resolved and the exacerbation that she experienced in September of 1997 had not improved at all. [Appellant's doctor #2] found no disk nor vertebral abnormalities; sacroiliac joints were normal, as was the thoracic spine. [The Appellant] also reported to [Appellant's doctor #2] that, prior to her MVA, she had been healthy, with no history of any back trauma nor other significant medical illness, other than depression for which she had been seen by three psychiatrists for counseling and drug management. She reported that her depression was well controlled and that she was almost back to normal by the end of 1996. She had experienced marital difficulties, was separated in 1994 and divorced in the fall of 1997.

[Appellant's doctor #2] assessed [the Appellant] as having chronic mechanical and myofascial pain syndrome of the paraspinal muscles. She had a multiplicity of trigger points and displayed restricted movement of the joints. She was not coping well with her pain and functional impairment; she was depressed. [Appellant's doctor #2] recommended discontinuance of any formal physiotherapy treatment for the time being and suggested the substitution of a multidisciplinary comprehensive rehabilitation program.

Following a further assessment of [the Appellant] by [Appellant's doctor #2] on February 5th, 1998, she told him that her neck mobility had improved and her headaches had lessened. She still got occasional sharp pain in the shoulder joints but was sleeping better. [Appellant's doctor #2] felt that she had made significant improvement in the trigger points of her lower back and buttock muscles but still had active trigger points in the sternocleidomastoid and trapezius muscles bilaterally. He applied the usual spray-and-stretch treatment to the affected muscles, arranged for [the Appellant] to obtain further home-stretching exercise instruction and advised her to start aerobic conditioning exercises to improve her endurance and strength.

[Appellant's doctor #2], not having seen [the Appellant] until March of 1997 but in reliance upon the history and information given him by [the Appellant], felt that her symptoms were most likely related to her MVA. He was unable to express an opinion as to the Appellant's capability of performing her job duties as a library assistant, contenting himself by noting that she had low endurance for any medium to heavy and repetitive activities and work. He suggested that, once the active trigger points had been resolved, a Functional Capacity Evaluation might be valuable. He added that [the Appellant] "would benefit by further comprehensive rehabilitation program provided by physiotherapist, occupational therapist, psychiatrist and clinical nurse specialist".

He anticipated that [the Appellant's] active trigger points would be resolved and her soft tissue pain and spine mobility would have improved by the beginning of March 1998. Finally, he expressed concern about her depression which, if not well controlled, he felt might cause her symptoms to linger.

By March 13th, 1998, [Appellant's doctor #2] was able to write to MPIC's Case Manager to confirm, firstly, that the job description for [the Appellant], according to the National Occupational Classification, certainly appeared to be light-duty work and that [the Appellant] should be able to perform the requirements of that job, particularly if it did not involve too much repetitive bending, lifting and carrying. "If she is given option by her employer that she may take rest in between during these activities and work, then in my opinion she can return to this work." [Appellant's doctor #2] also reported that [the Appellant's] multiple myofascial trigger points of the muscles had all resolved, her sleep pattern had improved and her energy level was better. She was still, however, mildly depressed and had low endurance for any prolonged sitting, standing, repetitive bending and lifting activities. He had referred [the Appellant] to [rehab clinic] for conditioning and strengthening exercise programs and to educate her in proper ergonomics to prevent mechanical stresses on her spine and restore her function. He felt that four weeks of that program should be sufficient.

From April 9th to April 21st, 1998, [the Appellant] was away on a visit to [text deleted] where, she said, she would continue her pool exercises. Upon her return, she resumed physiotherapy where her energy level was reported to have been increased. This was confirmed by [Appellant's doctor #2's] report of May 19th, which speaks of "significant improvement in her mechanical neck and shoulder girdle pain syndrome. The regional myofascial trigger points have resolved. Still she has mild weakness of the neck muscles with low endurance of the torso

and the shoulder girdle muscles". [Appellant's doctor #2] again recommended a further three to four weeks of strengthening and conditioning exercises.

On June 8th, 1998, [text deleted], [the Appellant's] psychiatrist, addressed a letter to MPIC's Case Manager. He reported that he had been seeing the Appellant since February 13th, 1996. He had been treating her for borderline personality disorder, and she had experienced periods of depression, anger and paranoia. The symptoms tended to fluctuate. He had prescribed Prozac and weekly sessions of psychotherapy. [Appellant's psychiatrist #1] was not aware that [the Appellant] had been involved in a MVA until a session that he held with her on October 22nd, 1997. [Appellant's psychiatrist #1] noted that, on that and several subsequent visits, [the Appellant] had spoken of her enjoyment of her work but of her headaches, back and neck pain for which she was receiving physiotherapy. He could see no causal link between her psychological condition and her injuries; he opined that "the time she may have taken off work was not related to her psychological condition. She did not get any medical certificate from me".

A report of June 5th, 1998, from [rehab clinic] shows that full cervical and lumbar spine ranges of motion had been achieved, that the Appellant's reconditioning program was underway and that she now had minimal symptoms. The physiotherapist recommended a three-month membership at the [gym] so that [the Appellant] might continue her exercises and further her strengthening. "There are no physical findings at this time which would preclude her from returning to her job in September '98". It is noteworthy that [the Appellant] apparently took issue with that report, saying that she lacked the energy and endurance to return to work. The physiotherapy report had simply forecast her ability to do so in September, but [the Appellant] did not seem to feel that she would be able to achieve that goal.

On June 18th, 1998, the Case Manager wrote to [the Appellant], confirming earlier advice that, in the view of the insurer, available medical information did not confirm a level of functional impairment sufficient to preclude her from performing the duties of her pre-accident occupations. Income replacement was therefore denied.

On June 24th, 1998, [Appellant's doctor #1] wrote to MPIC's Case Manager. She noted that [the Appellant], having been "totally disabled from April 30th, 1997" - a comment which, we are constrained to say, was simply incorrect - had returned to work in October 1997. [Appellant's doctor #1] went on to confirm many of the facts set out above. She concluded that the Appellant had "suffered from whiplash along with myofascial pain. Past history of depression also has some part to play. She may need a lot of encouragement and supportive therapy to make her ready to return to work along with continuing strengthening exercises which patient can do herself".

On August 14th, 1998, [the Appellant] consulted [text deleted], Chiropractor. He reports that she complained of "significant neck, thoracic and lower back pain as well as headaches, dizziness, ringing in the ears, numbness and tingling in the legs, bilateral hip pain, she felt depressed since the accident as the problem has been going on for quite some time with no resolution and no change in her symptoms".

[Appellant's chiropractor] listed his findings as

> .....significant restriction in the cervicals, thoracic and lumbar spine. Subluxations were noted at several levels. Muscular hypertonicity was noted.....Some positive orthopaedic and neurological tests which I will elaborate on in my Treatment Plan Report, to follow.

[Appellant's chiropractor's] Treatment Plan Report does not seem ever to have been provided.

[Appellant's chiropractor], having diagnosed severe hyperextension/hyperflexion sprain/strain injury to the cervical, thoracic and lumbar spine and its associated soft tissues, reported that, in his view - a view differing markedly from that of [Appellant's doctor #1] - [the Appellant] had sustained a Grade 3a Whiplash Associated Disorder. He felt she would need from eight to twelve months of chiropractic adjustments in order to correct dermatomal deficits and myotomal weakness at the C6 to C8 and L5 levels of [the Appellant's] spine, and to deal with reflex changes at C7 and L5 levels. He believed, however, that she should be functional and back at work within a few months after August 14th, 1998. MPIC paid for [the Appellant's] chiropractic care until October 15th, 1998 although, she testified, she continued to see [Appellant's chiropractor] sporadically at the expense of her father. [Appellant's chiropractor] had been able to relieve the "small section of my mid-back where three sections of my spine seemed to be locked together".

On August 19th, 1998, [text deleted], the Nurse Clinician who had been giving counseling and exercise education to the Appellant, advised MPIC's Case Manager that she could find no reason why [the Appellant] could not return to work in September of 1998. She reported the Appellant as being upbeat, positive and looking forward to going back to the [text deleted] job after the September long weekend. [The Appellant] was also apparently taking some university courses on a part-time basis.

On August 30th, 1998, [the Appellant] filed an application for a review of the Case Manager's June 18th decision letter. She also sought certain other benefits that had been denied by the Case Manager, but that are not relevant to the present appeal.

[The Appellant] did return to work on September 8th, 1998 and, on September 24th, her supervisor at the [text deleted] reported that the Appellant was "doing well.....able to do all the functions of her job". In consequence, the Case Manager wrote to [the Appellant] on September 25th to tell her that no further chiropractic care would be provided at MPIC's expense beyond October 15th, 1998.

On October 9th, a further report was sent by [Appellant's doctor #2] to MPIC's Case Manager. [Appellant's doctor #2] reported that [the Appellant's] mechanical and myofascial pain had resolved and that her mood and depression had significantly improved. While she still had low endurance for any repetitive (moderate) to heavy activities and work, she had full spinal range of motion and appeared to need only an endurance enhancing program at the [gym] for the next three or four months following his last assessment of her on July 11th, 1998. She had been given follow-up appointments on August 6th and September 14th but had not attended either of them. Since her myofascial pain had resolved and "there was no musculoskeletal or neurological deficit", [Appellant's doctor #2] saw no indication for any further aggressive manipulations nor any formal physiotherapy treatments. From the context of that advice, we take it that [Appellant's doctor #2] was also negating the need for further chiropractic manipulations. That was confirmed by further letter from [Appellant's doctor #2] on November 3rd, 1998, wherein [Appellant's doctor #2] reports that [the Appellant] had returned to work at five hours per day, five days per week. She had been seeing a chiropractor and had received about twelve aggressive manipulation treatments. Since September 1998 she had been experiencing headaches, starting around noon and increasing by the evening, in the cervico- thoracic region radiating to the occipital area. She had no evidence of active trigger points, she had full range of motion of the neck, her motor strength had improved except that she had low endurance for any

prolonged sitting, standing and repetitive lifting and carrying activities. [Appellant's doctor #2] advised that

> She must discontinue aggressive chiropractic manipulations. Aggressive manipulations can cause musculoligamentous strain and worsening of her symptoms and functional level. I stressed the point that regional myofascial pain has resolved. She does not have any disc herniation, nerve injury or instability of the cervical spines.

[Appellant's doctor #2] advised regular exercise, mainly cervical stabilization exercise in which the Appellant had been educated. He recommended she should continue the activities and her job "as tolerated". He was hopeful that, by continuing with that program, she would be able to increase her working hours to eight per day. All of her ranges of motion and reflexes were normal; only the motor strength of her neck muscles were still slightly weakened, being graded 4+ out of 5.

Despite [Appellant's doctor #2's] opinion and advice, and although she worked back at her [text deleted] job from September 8th to December 4th, 1998 (the beginning of the normal layoff period) her new supervisor told her that she would have to decide whether she would be returning to work on January 4th. She decided not to do so because, as she testified, "I just couldn't do it".

An Internal Review of the Case Manager's decision of June 18th was held on October 23rd, 1998. That portion of the Internal Review Officer's decision of November 18th, 1998, relevant to the present appeal finds, in essence, that [the Appellant's] work both at [text deleted] and at [text deleted] fell into the classification of "light work" and that there was no medical evidence to support the suggestion that her MVA-related injuries precluded her fulfillment of the requirements of either of those jobs.

[The Appellant] has appealed to this Commission from the Internal Review Officer's decision, at least in the context of her entitlement to IRI, by Notice of Appeal bearing date January 15th, 1999.

A narrative report from [Appellant's chiropractor] of March 29th, 1999, addressed to this Commission, contains the information reflected in his Initial Health Care Report following his examination of the Appellant on August 14th, 1998. He comments that [the Appellant] had been under care from [Appellant's doctor #1], [Appellant's doctor #2] and [text deleted] (neurologist) for the year and a half after her accident, "with little or no improvement". He seems to have been told, or to have believed, that the only treatment [the Appellant] had received was in the form of medications for her pain which, he concluded, over time had led to depression and anxiety for which more drugs were prescribed to deal with these side effects. [Appellant's chiropractor] was either ignoring, or had not been made aware of, the lengthy and successful treatments received by the Appellant, particularly from [Appellant's doctor #2], and of the fact that her depression and anxiety states predated her MVA by several years - [the Appellant] testified she had first been diagnosed with clinical depression in 1992. [Appellant's chiropractor's] report also speaks of an "improvement in allergies", which seems to be the first and only reference to any allergies on the part of the Appellant.

[Appellant's chiropractor], who first saw [the Appellant] 17 months after her MVA, reported that she had been suffering from significant cervical and lumbar subluxations causing nerve root irritations, muscle spasms which lead to cervicogenic headaches, pain, tingling and numbness into the arms and the legs, depression, fatigue and anxiety. He believes that the treatment she received in the first year and a half following her MVA "did not address spinal imbalances and

subluxations that were present, due to her accident". This, he says, caused "significant scar tissue and muscular adhesions to form, thus limiting and delaying her recovery". [Appellant's chiropractor] also reported that [the Appellant] had shown signs of improvement throughout August and September of 1998. He expressed his belief that, if she continued under regular chiropractic care to correct her spinal misalignments and imbalances as well as undergoing a strengthening and reconditioning program, she would be able to return to her work duties on a full-time basis with only limited functional impairment. He estimated this would take from six to nine months of chiropractic care at a frequency of three visits per week for eight weeks, decreasing progressively as stability was achieved, in conjunction with a supervised exercise program at least three times per week.

[Appellant's chiropractor's] letter did not bring about a variance in MPIC's decision to cease funding chiropractic treatments as of October 15th, 1998.

[The Appellant] was able to retain the services of counsel, who obtained a report from [the Appellant's] new psychiatrist, [text deleted], to whom the Appellant had been referred by [Appellant's doctor #1]. [Appellant's psychiatrist #2's] report of May 14th, 2000, outlines a troubled history of mental health from 1992 to the present time and contains a diagnosis of major depressive disorder as well as significant personal problems. He describes the pattern of anti-depressant medications that had been prescribed for her by her first psychiatrist, [text deleted], in 1993, and by [Appellant's psychiatrist #1] from February 1995 to January 1999, as well as the prescriptions given her by [Appellant's psychiatrist #2] himself. He reports, further, that "She appears to be unable to perform any meaningful work at this point, due to both her physical and mental symptoms". The psychiatric factors limiting the Appellant's ability to work included poor energy and drive and difficulty concentrating. [Appellant's psychiatrist #2] said that he could

not comment with any validity as to the role of the MVA of March 2nd, 1997, in [the Appellant's] psychiatric condition. Psychiatric problems obviously began well before that date but this did not rule out the possibility that her symptoms were exacerbated by the accident. He could not measure any impact that the MVA might have had.

The Commission has also been provided with a copy of a letter from [Appellant's doctor #2] to [text deleted], a corporation that carried insurance on [the Appellant's] life as partial security for a personal loan. [Appellant's doctor #2's] letter to [text deleted] is dated November 1st, 1999. In it, he covers in substantial detail all of his reports referred to earlier in these Reasons. In particular, he notes that by March 9th, 1998, [the Appellant's] pain was tolerable and she had not major relapses, her neck and back ranges of motion being within normal limits. Her multi-myofascial trigger points of the muscles had resolved. By June 11th, 1998, her strength and energy level had improved. By December 10th, 1998, [Appellant's doctor #2] was emphasizing his earlier advice to the Appellant that she should avoid any aggressive manipulations of the cervical spines with the fear of suffering vertebral basilar insufficiency. [The Appellant] had complained, at that date, of dizziness and pain around and between the shoulders, which [Appellant's doctor #2] felt may have resulted from her chiropractic manipulations.

[Appellant's doctor #2's] letter of November 1st, 1999, also reported that a CT Scan of the Appellant's cervical spine, from C3 to T1, showed no bony, soft tissue, disc or articular abnormality. Similarly, X-rays of her lumbar and thoracic spines had shown no significant abnormalities, no discs nor any vertebral problems and normal lordosis. [Appellant's doctor #2] said

> In summary, [the Appellant] has developed chronic pain syndrome which was initiated by trauma which was further precipitated by major stressors including anxiety and sleep disturbances. In spite of appropriate treatment she has not responded well and continues

> to experience soft tissue pain, low energy level and continues to be deconditioned. Investigations have not revealed any evidence of endocrine deficiency or other medical causes which may perpetuate her symptoms.

[Appellant's doctor #2] recommended stress management, a continuance of anti-depression and anti-anxiety medications, relaxation exercises, the avoidance of daytime napping and the continuance of aerobic and lightweight exercises. He had referred the Appellant to [text deleted] for vocational assessment, counseling and training.

[Appellant's doctor #2] also advised [text deleted] that the only functional restrictions or limitations he had placed on [the Appellant], in the context of employment, was that she should avoid any repetitive bending, lifting and carrying activities, but he noted that she should be able to stack away microfilms on the shelf and in filing cabinets as a library assistant. He felt [the Appellant] would benefit by management of her chronic pain syndrome by a multi-disciplinary team and further vocational counseling. He recommended strongly that she be encouraged to return to gainful employment within a short period.

The Commission was also provided with a copy of the report of [text deleted], physiatrist, following his examination and assessment of [the Appellant] on February 18th, 2000. After relating the history given him by [the Appellant], and describing substantially normal results from his examination (other than increased pain sensitivity in soft tissue of both the upper and lower body), [independent physiatrist] concluded that his findings were consistent with a diagnosis of fibromyalgia syndrome. As he puts it "This diagnosis is currently controversial and there is no specific pathoanatomic abnormality that has been identified. As well, the available literature suggests that causal linkage between fibromyalgia syndrome and specific injury cannot be established. He advised [the Appellant] to increase gradually her general activities, bringing

her physical activities to an aerobic level. He also suggested that she consider utilizing, on a regular basis, the stress reduction and management techniques she had already learned. He felt that the prognosis for complete restoration of function was good and that, in the condition in which he found her, [the Appellant] was capable of resuming her pre-accident activities.

The final medical reports provided to us consist of two memoranda prepared by [text deleted], Medical Consultant to the Health Care Services Team of MPIC, bearing date November 14th and 21st, 2000 respectively.

[MPIC's doctor], in reviewing [independent physiatrist's] report, agrees with it and points out that

> Diffuse tenderness is not objective evidence of an impairment of musculoskeletal function that would, in turn, prevent [the Appellant] from performing her regular day-to-day and pre-collision occupational duties. [Independent physiatrist's] opinion pertaining to [the Appellant's] level of function is in keeping with the opinion I formulated based (upon) my previous reviews of [the Appellant's] file.

[MPIC's doctor's] memorandum of November 14th addresses three questions:

1. whether a multi-disciplinary team approach, with further vocational counseling for management of a chronic pain syndrome, was a medical necessity in the management of conditions arising from [the Appellant's] MVA;
2. whether a functional capacity evaluation would provide useful information; and
3. whether any documentation then available contained new medical information establishing [the Appellant's] inability, either physically or psychologically, to perform the duties of a Library Assistant II.

[MPIC's doctor] noted that [Appellant's doctor #2], in his January 4th, 1999 report, indicated that the Appellant's psychological difficulties seemed to be well controlled and unlikely to interfere with her difficulty to perform her occupational duties. [Appellant's doctor #2's] examination had been relatively unremarkable and identified no impairment of physical function involving the spine or extremities that might have prevented the Appellant from doing her job. There was no documentation that [Appellant's doctor #2] had advised [the Appellant] to discontinue her work.

In a critique of [Appellant's chiropractor's] report of March 29th, 1999, [MPIC's doctor] comments, in part:

> I am unaware of any medical and/or chiropractic literature that identifies the development of significant scar tissue and muscular adhesions from minor soft tissue strain that does not result of any loss of spinal range of motion and improves with conservative treatments implemented. In other words, [Appellant's chiropractor's] opinion with regard to the development of significant scar tissue and muscular adhesions has no scientific merit. The examination findings identified by the health care professionals involved in [the Appellant's] care prior to [Appellant's chiropractor's] involvement do not identify any findings that would suggest the development of significant scar tissue or muscular adhesions.

Commenting that nothing in the medical or chiropractic literature would support the need for spinal manipulation to correct a minor muscular tenderness strain, [MPIC's doctor] also noted that [Appellant's chiropractor's] recommendation for six to nine months of care did not conform to the chiropractic guidelines, particularly if consideration were given to the medical evidence provided by the health care professionals who provided the Appellant's care prior to [Appellant's chiropractor's] involvement. Finally, in this context, [MPIC's doctor] noted that even [Appellant's chiropractor's] report did not contain documentation identifying [the Appellant] as being physical unable to perform the duties of a Library Assistant II.

[MPIC's doctor's] memorandum of November 14th then proceeds to a careful analysis of [Appellant's doctor #2's] report of November 1st, 1999, addressed to [text deleted], from which he concludes that, throughout 1998 and the early part of 1999, [the Appellant's] spinal range of motion remained full and there was no evidence of active trigger points or neurological deficits. Neither the CT Scan nor any blood tests identified any abnormalities that would account for [the Appellant's] symptoms. Although the Appellant had resigned from her job as a library assistant as a result of symptoms, [Appellant's doctor #2's] examination findings at that time were in keeping with his findings when she was working. He had never advised her to discontinue her work duties. Medical examination findings were relatively unremarkable and [MPIC's doctor] opined that [the Appellant's] decision to resign from her job was based on her ongoing symptoms, even though a medical condition had not been identified to account for those symptoms. There was no information available to indicate why [Appellant's doctor #2] had referred [the Appellant] to [text deleted] for vocational assessment counseling and training, particularly since the medical evidence did not identify her as being physically unable to do her work.

According to [Appellant's doctor #2's] November 1st, 1999 report, [the Appellant's] mechanical and myofascial pain, to the origin of which the motor vehicle collision might have been a contributing factor, had resolved.

> It would be unusual for a mild soft tissue injury that did not result in any limitation of spinal range of motion and improved with initial treatment interventions to contribute (to) the development (of) myofascial symptoms some time later.

Referring to a vocational assessment report that had been furnished by [text deleted] on January 14th, 2000, [MPIC's doctor] notes that [the Appellant] had selected several jobs in which she had a particular interest, any one of which would have exposed her to physical demands exceeding

those required of a Library Assistant II. Although this assessment described [the Appellant] as being unable to handle the physical and emotional demands that were part and parcel of work or work training, there was nothing in the assessment report to indicate how that fact had been determined. One had to assume that it was based on information obtained directly from [the Appellant] rather than from any formal evaluation of her functional capacities.
(*The qualifications of the assessor were not made known to the Commission.)*

Noting that [Appellant's psychiatrist #2], on May 24th, 2000, had reported that [the Appellant] suffered from symptoms of major depressive disorder and significant personality problems, and that her mental symptoms had been present over the past eight years, [MPIC's doctor] pointed to the fact that, from [Appellant's doctor #2's] report, it appeared that [the Appellant's] psychiatric symptoms were well controlled during the time she was receiving treatments for her physical symptoms. This, said [MPIC's doctor], would lead him to conclude that any involvement the MVA might have had in exacerbating prior, psychiatric symptoms had resolved, and that any ongoing difficulties she might still experience were probably related to her pre-existing condition.

[MPIC's doctor] therefore concluded that:

(a) [The Appellant's] vehicle had sustained very minor damage and her initial examination had not identified any significant physical findings. Her mechanical myofascial symptoms had resolved and, if she had experienced an exacerbation of her former psychiatric condition, the medical evidence indicated that the exacerbation had also resolved in all probability;

(b) [The Appellant] had developed chronic pain syndrome - a condition wherein pain is no longer a manifestation of underlying tissue pathology but wherein the pain itself has now

> become the disease. Performing a Functional Capacity Evaluation on an individual with chronic pain syndrome would be of no value, since that person's subjective complaints of pain would adversely affect his or her ability to perform the various functional tasks; the results of such an evaluation would not be a true reflection of the individual's functional capabilities.

While [MPIC's doctor's] November 14th, 2000 memorandum does not address the medical necessity of a multi-disciplinary team approach and further vocational counseling, this is presumably because he had already concluded that [the Appellant's] condition, whatever name might be given to it, was not related to her motor vehicle accident.

One of the principal issues with which we need to deal is whether [the Appellant] was, in fact, capable of resuming her duties as a library assistant. From the formal job description provided to us, there is little doubt that her work in that capacity falls into the category of "light duties" and should have been well within her functional capabilities. However, [the Appellant's] oral evidence was that the formal job description did not tell the whole story. One of her duties was to file and also to recover microforms, that is to say rolls of microfilm, microfiches and microcards. These were stored in cabinets five to six feet high, whereas [the Appellant] is only five feet two inches. Some drawers were above her head; some were below waist level. She would spend about two hours per day filing microforms, though those duties were spread throughout the day and not concentrated in any one particular time frame. She had encountered no difficulty with this facet of her work before her MVA, but thereafter the pain was too great to allow her to perform this duty. She also had to keep equipment clean, frequently having to move an entire machine in order to get to the back of it. She would spend one to two hours daily, cleaning machines, refilling toner in printers and photocopiers. She also had some desk work to

perform, for about one hour per day, but this meant getting up and down, helping [patrons] to locate source materials, showing them how to use the library equipment, and so on. She had to assist [patrons] "dozens and dozens of times each day throughout the five hour shift".

Similarly, [the Appellant] testified, the formal job description of her work at [text deleted] only told half the story. Firstly, she spent several more hours each week than was actually called for by the job description, obtaining [text deleted] supplies, setting things up for the students, discussing plans with senior coordinators, moving lights, bending and stretching, carrying [text deleted] supplies and working with up to thirty children at a time. She had tried to conduct one post-MVA class, but found it was more than she could handle. She had tried to keep going with her normal domestic activities, gardening, housekeeping and the like.

[The Appellant] testified that, currently, she attends computer classes from 8:30 to l1 A.M. three times a week, then goes home to sleep. She goes to bed at night at about 10 o'clock, but her sleeping is becoming increasingly disturbed with the stress of her computer course. She has "pretty constant pain" in the neck and back while working at her computer classes. She is taking Ibubrofen, Robaxacet, extra strength Tylenol and 60 to 80 milligrams of Prozac on a daily basis. [The Appellant] also testified that she takes 5 milligrams of Elanzipine (an anti-depressant prescribed by [Appellant's psychiatrist #2]) each night, as well as Lorazepam, an anti-anxiety drug. She was on a dosage of 60 milligrams of Prozac daily at the time of her MVA, having first been diagnosed with depression in 1992 and having been off work from April through September of 1996 due to marital and other stress. She tries to do her stretching exercises every day "although I don't do the entire course every day". She walks daily "if I am healthy enough", but says that she gets a lot of hip and back pain. The basic things of life seem to take all her energy and the simple acts of cooking and eating a meal leave her exhausted. She does her own

shopping and banking, but those tasks take her twice as long as usual. Doing two loads of laundry is a major accomplishment.

[The Appellant] testified that, although her clinical depression had been diagnosed in 1992, her psychiatrists had told her that it had probably originated well before that. After her MVA, she found that the anti-depressant drugs were less effective; she started having anxiety problems and more sleep disorder. [The Appellant] said that she probably would not have told [Appellant's psychiatrist #1] about her MVA until October of 1997 because she had not, until then, connected her anxiety attacks with her MVA. "The motor vehicle accident had not become such a huge issue; I had other problems to deal with in those one-hour psychotherapy sessions".

The Appellant further testified that she had seen [Appellant's doctor #2] first, on referral from [Appellant's doctor #1], on January 8th, 1998. She had also seen [text deleted], neurologist, in November of 1997. The Commission was not provided with any report from [Appellant's neurologist #1], although [the Appellant] testified that he had suggested that, because of the stress of her divorce, the MVA might have had a more serious effect upon her system. If that was said, we take it to mean that the marital discord had created a psyche that was more fragile and, therefore, more susceptible to disruption by even the comparatively minor trauma of [the Appellant's] MVA than would otherwise have been the case.

Following [Appellant's doctor #2's] advice, [the Appellant] attended at [rehab clinic] five days a week, doing acquasizes, receiving physiotherapy, transcutaneous electrical nerve stimulation and counseling from nurse specialist [text deleted]. [The Appellant] told the Commission that [Appellant's nurse specialist] "thought I could do a lot of therapeutic things on my own that I really didn't think I could do". She finished her program at [rehab clinic] on June 5th, 1998 and

had no further treatment nor exercise program until sometime in July when MPIC bought her a pass for the [gym] with the primary purpose of continuing her acquasizes.

[The Appellant] testified (contrary to [Appellant's doctor #2's] recollection) that she had been to see [text deleted] on the suggestion of a friend, for vocational assessment. [Appellant's doctor #2] had become aware of that, but he had not recommended it. She did not know what qualifications were held by the vocational evaluator or by others with whom she had worked. She attended for assessment from 9 A.M. until noon, later extending those hours until about 3:30 P.M. She had attended for about three weeks in order to have her vocational assessment completed, and had then volunteered to work at the [text deleted] premises, initially for three afternoons per week but cutting that back to once weekly. She had quit altogether when starting her current computer course.

[The Appellant] agreed that it was quite possible she had told [Appellant's doctor #2] that her depression was under control, yet had told [Appellant's psychiatrist #2] that she was still seriously depressed. She also goes to interfaith counseling at [text deleted] and to the [text deleted], for additional counseling. Her counseling, she said, is unrelated to her pain but is, rather, directed to the origins of her depression.

[Appellant's doctor #3], her current family physician, or [Appellant's doctor #1], had referred her to [independent physiatrist] in February of 2000 for an independent assessment. [Appellant's doctor #3] had also referred her to [Appellant's neurologist #2] for a CT Scan which, apparently, was to take place in the evening of the day upon which her appeal was heard. That diagnostic procedure was apparently directed towards her continual headaches. She had also fallen down

stairs at [text deleted] six weeks prior to the hearing of her appeal; she had hurt her left leg and an X-ray had indicated an old fracture which, seemingly, is unrelated to her MVA.

On cross-examination, [the Appellant] agreed that she had started to experience fibromyalgic symptoms some time in mid-to-late 1999, some two and one half years after her motor vehicle accident. She had changed from [Appellant's doctor #1] to [Appellant's doctor #3] because she felt her health was not being looked after very well and she wanted a second opinion. She had changed from [Appellant's psychiatrist #1] to [Appellant's psychiatrist #2] at [Appellant's doctor #1's] suggestion. Appointments had been made for her to be examined by [text deleted], rheumatologist, but she had missed one such appointment and had been unable to keep the second appointment due to illness. She saw herself as having a high pain tolerance level and felt that the main barriers to a return to work were fatigue and pain. After her current computer course, she expected to be placed in a temporary, unpaid job to help her get ready for a gradual return to work. [Text deleted] would organize this for her, she believed.

SUBMISSIONS BY COUNSEL FOR THE APPELLANT:

[Appellant's representative] emphasizes the facts that, prior to her MVA, [the Appellant] had been physically healthy and even her depression was under control and not adversely affecting her employment or her general functional capacity. She was also an active artist. Her periods away from work prior to her MVA had been due to marital problems, her sister's wedding and a desire to find better employment than had earlier been available to her. As a result of her MVA, [the Appellant] had been obliged to miss work from November 25th, 1997 to April 30th, 1998, from December 4th, 1998 to April 30th, 1999, from September 1st to April 30th, 2000, and from September 1st, 2000 to date. She had also missed the opportunity to earn $20 per hour for three and one-half hours every Saturday from mid-March 1997 to date at [text deleted]. (We note, in passing, that if this appeal were to be successful this is something that would need to be checked, since it is by no means clear that the children's classes in which [the Appellant] was involved ran for 52 weeks every year.)

[Appellant's representative], referring to the job demands description furnished to the Commission, submits that, no matter what the Canadian Dictionary of Occupational Classifications says, the question is what [the Appellant] actually had to do. In fact, it was a very physical job, requiring [the Appellant] to repeatedly pull out and push in heavy drawers in the course of a five-hour day. Similarly, helping her students at [text deleted] entailed much bending and movement of the cervical spine. While [Appellant's doctor #2] may agree that this is light work, he is basing this on the job descriptions provided to him by MPIC. The work at [text deleted] was not sedentary but was, rather, very physical.

Despite her pre-MVA physical health, the Appellant had started to feel a sore neck, a locking of her jaw, sore back and pain in her leg even at the scene of her accident.

[Appellant's doctor #2] obviously found and treated medical conditions which must have arisen from the motor vehicle accident - no other source is realistically suggested by any of her caregivers nor even by MPIC's Medical Services Team. MPIC continued to fund her physiotherapy, her program at [rehab clinic] and her acquasize program the [gym]. By assuming responsibility for those forms of therapy, [Appellant's representative] submits, MPIC is obliquely acknowledging that [the Appellant's] continuing problems stemmed from her MVA and should therefore assume responsibility for the payment of income replacement indemnity under Section 84(1) of the Act. [Appellant's representative] asks, rhetorically, how in any event [the Appellant] could have returned to work while attending [rehab clinic] and other rehabilitation programs paid for by MPIC.

[Appellant's doctor #2], in his report of November 1st, 1999, to [text deleted], says that [the Appellant] has developed chronic pain syndrome "which was initiated by trauma" and which was further precipitated by major stressors including anxiety and sleep disturbances. The only trauma of which there is any evidence is that of the motor vehicle accident. The Appellant's prior depression had not prevented her from working two jobs concurrently before her accident and, if that pre-existing depression was an added factor in causing or prolonging the chronic pain syndrome, so be it; MPIC has to take its victims as it finds them. Not only MPIC but, as well, some of [the Appellant's] caregivers have been too quick to attribute her ongoing, physical difficulties to her prior, psychiatric problems. [Appellant's doctor #2's] recommendations for a multi-disciplinary team, functional capacity evaluation and work hardening programs all appear to have been ignored.

[Appellant's representative] submits that, just because much of the evidence is subjective, that does not mean that the evidence is not genuine and valid. No one has yet offered a concrete plan likely to restore [the Appellant] to her pre-MVA condition, in the context of her functional capacity. If that cannot be done, she should be retrained for some occupation that she can, in fact, hold.

[Appellant's representative] refers this Commission to its own decision in the appeal of [text deleted], a decision of March 8th, 1999 which, on its face, has much in common with [the Appellant's] case. We shall return to the [text deleted] decision later in these Reasons.

SUBMISSION ON BEHALF OF MPIC:

Ms. McKelvey, for the insurer, emphasizes that the accident in question was, by any standard, a minor one, that both the Appellant's part-time jobs were rated as "light duty" and that [Appellant's doctor #1] had diagnosed her condition as being a Grade 1 Whiplash Associated Disorder, the mildest injury of its kind. The Appellant's physician had advised that she could work modified duties, limited only as to repetitive bending and lifting. The Appellant had, in fact, continued to work from the date of her accident on March 2nd, 1997 until the summer layoff on April 30th. She had, also, returned to work at the beginning of September and had continued working in her principal occupation until she had quit in November.

Further, said Ms. McKelvey, the Appellant does not seem to have thought it necessary to see her physician between early June and mid-September. Her physician, finding no objective signs, referred her to [Appellant's doctor #2]. Even then, there were no physical reasons for [the Appellant's] absence from work, and the psychological reasons predated the MVA.

Again, the physiotherapy report shows almost full range of motion and no suggestion that [the Appellant] was unable to function in the workplace.

While [Appellant's doctor #2's] first report speaks of no endurance for any medium to heavy repetitive work, [the Appellant's] jobs are both defined as light. The filing cabinets at the [text deleted] are on rollers and move out lightly; helping [patrons] is light work; cleaning screens and machines is light work; [Appellant's doctor #2] agrees that this is so. The physical strain of [the Appellant's] work as a library assistant is being exaggerated. For example, the need to move a machine in order to get at its back for cleaning purposes is hardly a daily occurrence and, without a doubt, help for that simple task would have been available, just for the asking.

Her physiotherapist at [rehab clinic], in a report of June 5th, 1998, says there are no physical findings which would preclude [the Appellant] from returning to her job in September 1998.

[Appellant's psychiatrist #1], speaking of the Appellant's "fluctuating depressive disorder" did not even realize she had been involved in an MVA until October of 1997, nine months after the event. If the Appellant's problems flow from that MVA, it is incongruous that she would not have spoken of it to him before October.

Ms. McKelvey emphasized some of the points made by [MPIC's doctor] in his internal memoranda. Some of those points may be summarized this way:

(a) the finding of [Appellant's doctor #1] that, by April of 1997, [the Appellant] had regained full range of motion;

(b) the only significant pain produced by [the Appellant's] MVA was in the regions of her neck and upper back, and those areas seem largely to have resolved soon afterwards;

(c) after her program at [rehab clinic], [the Appellant] is described as pain free and using no analgesics, there are no active trigger points and she has full range of motion. [Appellant's doctor #2] reports that her regional myofascial pain has resolved;

(d) [Appellant's doctor #2] had never mandated the termination of [the Appellant's] work in late 1998, and all of the medical evidence confirms her ability to do light work;

(e) her vocational assessment in the year 2000 points to lessened stamina and depression as barriers to a graduated return to work, and the report from [Appellant's psychiatrist #2] of May 24th, 2000, speaks of [the Appellant's] psychological problems as having been extant for at least eight years; there is no evidence of any real stabilization at any time thereafter;

(f) [Appellant's psychiatrist #1] cannot relate the Appellant's psychological problems to her motor vehicle accident, nor vice versa; [Appellant's psychiatrist #2] can only say that such a relationship is possible, that he cannot do so with any real probability;

(g) [Independent physiatrist] offers the opinion that [the Appellant] can return to work at her pre-MVA jobs;

(h) Fibromyalgia was not so much diagnosed as heard about by the Appellant at a rehabilitation class. There is no mention of it in any of the medical reports until [independent physiatrist's] assessment and, even then, much of the available literature on the subject links fibromyalgic symptomatology with depression as being one of its strongly suspected causes.

DISCUSSION:

In deciding the appeal of [text deleted], referred to above in the submission of counsel for [the Appellant], this Commission was presented with facts which certainly have some strong similarities to the facts in the present case. [Text deleted] had been involved in two motor vehicle accidents, although neither of them appeared to have been very serious. Her first accident occurred in February of 1995 and the second in June of 1996. [Text deleted], just as [the Appellant], had sustained apparently mild injuries to her neck and to the cervical regions of her spine, resulting in some limitations of range of motion but no neurological deficits. Although [text deleted] would, in the ordinary course, have been restored to as close to pre-MVA condition as was possible within a reasonable time following her two accidents, her injuries did not follow the ordinary course: the healing process was seriously impaired by psychological barriers that were variously diagnosed as borderline personality disorder, chronic pain behaviour syndrome, chronic myofascial pain, and fibromyalgia syndrome or chronic fatigue syndrome, or both. While [the Appellant's] physical complaints, and the variety of diagnoses of her conditions, are not as all-embracing as those reflected in [text deleted] medical history, nonetheless we are confronted here with an accident victim who, although sustaining comparatively minor physical injuries, continues to complain of functional capabilities severely limited by pain and who has been diagnosed with clinical depression and borderline personality disorder. There are, however, certain distinguishing characteristics in [the Appellant's] case that differ from those in the [text deleted] appeal:

1. [The Appellant] did go back to work following her accident, and was able to complete the [text deleted] term ending April 30th, 1997;
2. [The Appellant] was able to return to work at the beginning of the fall term in September 1997, although she then used up her accumulated sick time and quit work on November 25th;

3. Extracts from [Appellant's psychiatrist #1's] clinical notes, together with his comments, are interesting and brief enough to be recorded here in full:

> The first time I became aware of her accident was on 22/10/97. She states "I am enjoying my work - I am happy about it. I have a problem - car accident March 97. I was off work for two weeks. I am constant pain. I am going for physiotherapy. I have a whiplash."
>
> On 12/11/97 she stated "I love my job. I don't get enough work. Because of the car accident I get headaches, back and neck pain".
>
> On 2/3/98 she states "I feel like going back to work, my back is better. I had a car accident in March 98 (*[Appellant's psychiatrist #1] obviously means 97*)".
>
> On 10/3/98 "I am still happy. I am being treated for my back. I get pain in my back and shoulders. I have to do stretch exercises. If I tried to do things the pain comes back".
>
> On 31/3/98 she said "I am coming back from physiotherapy exercises."
>
> There is no causal link between being treated for her psychological condition and her injuries. The time she may have taken off work does not relate to her psychological condition. She did not get any medical certification from me. There is no causal link between the medication she was taking and her injuries.

[Appellant's psychiatrist #1's] comments seem to draw a line of distinction between [text deleted] case and that of [the Appellant]. [Appellant's psychiatrist #1] is telling us that [the Appellant's] absences from the workplace were not related to her psychological problems whereas, in the [text deleted] appeal, we found that the effect of one or both of her accidents had brought to the surface the underlying psychological condition from which she was suffering. [Appellant's psychiatrist #1] is clear in his statement that "The time she may have taken off work was not related to her psychological condition. She did not get any medical certificate form me."

We have also been referred by counsel to the *Minister of National Health and Welfare v. Densmore*, reported in CCH Canadian Employment Benefits and Pension Guide Reports, No.

8508, wherein the applicant had sought a disability pension. The Review Committee had held that she was entitled to disability benefits and the Minister had appealed to the Pension Appeals Board. The decision of the Appeals Board, upholding that of the Review Committee, said, in part:

> This case again raises the difficult issue of whether an applicant for benefits may successfully invoke the definition of a disability contained in the Act based on the chronic pain syndrome and, if so, under what circumstances and on what evidence may she do so.
>
> This issue is difficult because its resolution depends upon the view which the Board ultimately takes of the genuineness of what are strictly subjective symptoms. In effect, the judgment call, made generally without the assistance of objective clinical signs, will be one of credibility on a case by case basis, as to the severity of the pain complained of.
>
> It is the Board's view, often expressed in the cases, that it is not sufficient for chronic pain syndrome to be found to exist. The pain must be such as to prevent the sufferer from regularly pursuing a substantially gainful occupation.
>
> ……It will be desirable, although by no means essential in all cases, for an applicant, and helpful to the Board, that evidence of a psychiatric or psychological or physiatric nature be adduced from medical practitioners who by virtue of their experience and general expertise in this difficult area of medicine are able to assist the Board.

In the Densmore case, the Pension Appeals Board was impressed by the genuineness of the applicant and, clearly, found her to be totally credible.

Counsel also referred us to a similar case, the *Minister of Human Resources Development (formerly the Minister of Employment and Immigration) v. Nicola Warrick*, also reported at CCH Canadian Employment Benefits and Pension Guide Reports, No. 8642. In this latter case the applicant's claim for a disability pension was based upon many, varied and wide ranging physical complaints. The Pension Appeals Board held that, while she had not established her disability on the basis of loss of function or functional pain, the evidence established disability due to fibromyalgia or chronic pain syndrome. In both Densmore and Warrick, however, there

were certain factors that are absent from [the Appellant's] case. Firstly, both Ms. Densmore and Ms. Warrick were found by the Pensions Appeal Board panel that heard their respective cases, to have been impressive in giving their evidence. Of Ms. Warrick, the Board said, *inter alia*, "Her story was replete with logic and continuity. It was clear and convincing. She showed every effort to be objective and truthful." Similar comments were made by the Appeals Board in the Densmore case. This Commission is not able to make the same observations with respect to [the Appellant's] evidence although we must make proper allowance for the possibility that [the Appellant's] own personality and cultural background, combined with her psychological problems, may have caused her to find the appeal process somewhat intimidating. The other, clearer distinction between [the Appellant's] claim and those in the Densmore and Warrick cases lies in the much greater extent to which they were apparently disabled by their chronic pain syndrome or fibromyalgia syndrome. Ms. Densmore, having undergone surgery for the removal of a malignant melanoma and a second intervention a few weeks later for the removal of lymph nodes, sustained drainage problems resulting in swelling and redness that persisted from 1985 through to the hearing of her appeal in 1993. A year after the removal of her lymph nodes, she began suffering right shoulder pain that also remained through 1993. She also had further surgery for the repair of a hiatus hernia. She had continued working as a Nursing Assistant in a nursing home for three years before giving it up as a result of her pain; none of the various treatments that had been tried was successful and the Pension Appeals Board found as a fact that she was incapable of working at all after November 1998, except for three days when she had tried working in March of 1990. The two physiatrists who gave evidence, one on behalf of the Minister and one for the respondent, agreed upon a diagnosis of chronic pain. One of those physiatrists concluded that any course of pain management treatment would be useless, and the Pension Appeals Board accepted that evidence.

The evidence of Ms. Warrick, which was substantially accepted by the Pension Appeals Board, outlined a wide variety of physical problems: poor and erratic vision, very little movement at all in her neck, shoulders and back with much inflammation of the entire spine; muscle spasm; inability to work, even a little, without exacerbating her condition by increase of pain and spasm and the subsequent reduction of movement; inability to drive or use public transport; inability to stand for periods of more than ten minutes or sit for more than thirty minutes without using a head rest; the need for frequent rest periods of lying flat; an ability to lift items of only three pounds, and to carry objects up to two pounds in weight over distances of only twenty metres; an ability to write for only three to four minutes at a time; a reliance upon other people to do daily chores, such as shopping, laundry, cleaning, general paperwork and correspondence; reduced concentration, fatigue, bleared vision, dizziness and tremor.

Unlike the foregoing cases decided by the Pension Appeals Board, while it seems clear that [the Appellant] did suffer from a regional myofascial pain syndrome, the physical manifestations of that appear to have resolved within a reasonable time following the ministrations of [Appellant's doctor #2]. The only diagnosis of fibromyalgia syndrome was made in August of 2000 by [independent physiatrist] and, as he says, the available literature suggests that causal linkage between fibromyalgia syndrome and specific injury cannot be established.

We agree with the Pension Appeals Board that a claimant who wishes to establish a right to income on the basis of chronic pain syndrome (to which one might add myofascial pain syndrome and fibromyalgia) must not only establish that the syndrome exists. The pain must be such as to prevent the sufferer from regularly pursuing a substantially gainful occupation. In our respectful view, [the Appellant's] evidence and that of all of her medical and paramedical caregivers, taken as a whole, falls short of meeting that criterion.

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

Dated at Winnipeg this 3rd day of January, 2001.

J. F. REEH TAYLOR, Q.C.

YVONNE TAVARES

F. LES COX