Automobile Injury Compensation Appeal Commission

IN THE MATTER OF an appeal by [the Appellant]
AICAC File No.: AC-97-138

PANEL:	**Mr. J. F. Reeh Taylor, Q.C. (Chairperson)** **Mr. Charles T. Birt, Q.C.** **Mrs. Lila Goodspeed**
APPEARANCES:	**Manitoba Public Insurance Corporation ('MPIC')** **represented by Mr. Don Hewak;** **[Text deleted], the Appellant, represented** **by [Appellant's representative].**
HEARING DATE:	**August 18, 1998**
ISSUE:	**Whether Appellant entitled to continued chiropractic care.**
RELEVANT SECTIONS:	**Section 136(1) of the MPIC Act and Section 5 of Regulation 40/94**

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 FACTS:

We must state, at the outset, that the only issue before us is whether MPIC was justified in its decision to cease paying for [the Appellant's] chiropractic treatments when it did so, in or about mid-July, 1997.

[The Appellant] was involved in two motor vehicle accidents (mva), the first on August 17, 1995, and the second on November 5, 1996.

The 1995 MVA.

[The Appellant] reported that, in the first mva, she was driving east on [text deleted] in [text deleted] when another vehicle turned left into the path of her vehicle. She described her injuries from that mva as "sore ribs, back, shoulder left, left knee scraped and bruised, rt. knee bruised, left elbow to fingers sore and bruised, neck, headaches, sore teeth for a couple days." She consulted [Appellant's doctor #1] at the [text deleted] who, following his examination of [the Appellant] on August 25, 1995, reported reduced flexion of the patient's back to 50% of normal, tender lumbar area, muscle spasm, 25% of normal range of motion of her neck, 100% elevation of left shoulder, and left arm bruising; he added "rib cage is quite firm and I think this is just muscle strain. Exam is consistent with significant musculoligamentous soft tissue injuries." He prescribed Advil, plus a muscle relaxant and physiotherapy 2-3 visits per week.

A subsequent examination by [Appellant's doctor #2], also of the [text deleted], on October 5, 1995, found that her symptoms had improved to a level that would allow her to return to work on October 23, 1995, but that she should continue with her physiotherapy and progressive exercises. [Appellant's doctor #2] added that, although [the Appellant] had not recovered entirely from her symptoms, she had "functionally recovered with her day to day capacity of employment and recreation and she may continue to experience episodic symptoms of neck pain and knee pain over the next 4-6 months".

Along with physiotherapy, [the Appellant] received chiropractic treatments twice a week.

At the time of her first mva [the Appellant] had been employed with [text deleted] as a passenger representative for some 22 years. She testified that, prior to this accident, she had enjoyed athletic activities, entertaining in her home and playing with her grandchildren, but that now she can not do these activities. She has had to depend on home assistance for household work and, since MPIC had ceased providing that assistance, her husband looks after all these responsibilities and has done all

the vacuuming, cooking, shopping and laundry. [The Appellant] testified that, following her 1995 mva of August 17, she was off work until November 25, 1995. Her work with [text deleted] encompassed ticket sales, standing, lifting and pushing baggage and wheelchairs as she assisted customers at check-in in the terminal and, at the gate, on- and off-loading passengers. On overseas flights there could be as many as 10-15 wheelchair passengers. She indicated that, as a result of the mva, upon returning to work she had had to ask for help but after a while her colleagues started to view her as a '5th wheel', since they could not always find the time or inclination to help her.

[The Appellant] returned to full time work on October 25 and 26, 1995, but, due to her apparent physical limitations, [text deleted], the Air Canada medical consultant, referred her to a reconditioning program with [text deleted] Clinic, three times per week until mid-November. She was then to undertake a graduated return to work program with restricted but unsupervised bending , lifting, pushing and pulling until November 25, 1995, when, [Appellant's employer's doctor] anticipated, she would be ready to return to full duties.

[The Appellant] testified that she had experienced significant recovery prior to the second accident with the physiotherapy and chiropractic programs and that she believed that she was 65 to 80% rehabilitated. She wrote to her adjuster on October 28, 1996, to say (in part) "At this present time no treatments are necessary." The reference is, clearly, to chiropractic treatments. Unfortunately, that bulletin proved a little premature, being issued some nine days before her next accident.

The 1996 Accident

Details of the mechanics of [the Appellant's] second accident on November 6, 1996, are rather sparse, but it seems clear that her car spun out of control after hitting a kerb, causing her to receive what she described to her physiotherapist as a 'knock on the back' - or so he reports. [The Appellant]

sought physiotherapy on the day following her second mva from her physiotherapist, [Appellant's physiotherapist], at [text deleted] Physiotherapy, who found muscle spasm to be present, along with tenderness in both the thoracic and lumbar regions of her spine, and recommended approximately four weeks of treatments involving massage, heat, ultrasound and mobilization exercises. She also advised no lifting or transferring for about 4-6 weeks and, in fact, that she remain off work altogether for about two weeks. [The Appellant] also consulted her family physician in [text deleted], [Appellant's doctor #3], on November 7. He diagnosed a sprain of her paraspinus muscles with referred pain into the lateral aspect of the right leg, indicated his view that she should be classed as having 'significant limitation in function, and prescribed Tylenol #3, Advil and physiotherapy.

[The Appellant] testified that she found the physiotherapy treatments did not provide much relief as she could not do the exercises and her lower back 'would grind'. She also tried acupuncture but it did not help. She said that all of her other caregivers agreed that she should have chiropractic treatments, as they appeared to have given her relief in the past. She therefore continued with her visits to her chiropractor, as will appear later in these Reasons. Meanwhile, she remained off work from November 6, 1996, until March 22, 1997, when she returned to work full time.

Since, despite her return to work, [the Appellant] was still complaining of low back pain, occasional numbness in the left thigh and calf, and difficulty in bending and lifting, [text deleted], her new family physician, referred her to [text deleted], an orthopaedic specialist at the [text deleted] Clinic, who saw her on July 2, 1997. He found that [the Appellant's] neck and upper limbs had good movements; her dorsolumbar spine movements were moderately restricted and slightly painful; there was lumbar paraspinal spasm and pain across the lumbosacral area; hips, knees and ankles had good movements; straight leg raising was 90% bilaterally; reflexes, sensations and power were all intact. X-rays showed considerable degenerative change of the cervical spine, with narrowing at discs C5-6-7; sacroiliac and hip joints were normal, but there were degenerative changes in the lumbar apophyseal

joint and slight narrowing at disc levels L3-4-5. [Appellant's orthopaedic specialist] recommended continued use of Ibuprofen and that [the Appellant] should limit excessive bending and lifting while working. That opinion was forwarded to [Appellant's doctor #4] on July 2, 1997; it was not made clear to us when, if at all, it was communicated to [the Appellant], although it may reasonably be assumed that she was either made aware of it by [Appellant's orthopaedic specialist] himself at the time of his examination of the Appellant or, shortly thereafter, by [Appellant's doctor #4].

Having returned to work full time on March 22, [the Appellant] experienced an exacerbation to her injury on July 25, 1997. She testified that she was assisting a passenger out of a wheel chair by bending down and lifting the foot pedals out of the passenger's way so that she could stand up. The passenger moved and [the Appellant] adjusted her position to accommodate the movement and then felt a sharp pain in her lower back which went right up to her neck. The pain caused her to fall forward and become immobilized to the point of needing assistance to get up and move to the staff area to lie down. She left the job-site on the advice of her supervisor, to see [Appellant's doctor #4], her personal physician. She was prescribed Tylenol #3 and told to remain off work until a further assessment.

[Appellant's employer's doctor], [text deleted], who had examined [the Appellant] on February 10, 1997, and had recommended that for the next 2-3 months she 'avoid pushing wheelchairs' and 'must continue physio', having re-examined [the Appellant] on August 6, 1997, classified her as permanently unable to return to the work for which she had been hired by [text deleted] - a view that seems to have been supported by [Appellant's doctor #4].

[The Appellant] stated her belief that she could end up in a wheelchair if her condition continued to deteriorate; she felt she was disabled. She had not been told specifically by any one physician that she could be in a wheel chair, but felt there was a suggestion of that outcome. She was under the

impression that she required constant chiropractic care and maintenance to prevent this outcome. She stated that she had been involved in no discussion whatsoever since July 25th, 1997, related to a possible return to work; she did not feel she could work in that same job as it would not be safe for herself or the public. She believes that her doctors will tell her when she is well enough to return to work.

[The Appellant] further testified that she had been receiving chiropractic treatments from [Appellant's chiropractor] and believed that those treatments had been of material help. She had tried to undertake her home exercise program, she said, but when she felt extreme pain she stopped; she had quit the home exercises altogether in the fall of 1997.

Today, [the Appellant] testified, her mobility has improved and she has more back and neck movement and less pain. She can get into her car more easily, and she doesn't hurt as much because she has learned how to move without having pain. She does not have scheduled chiropractic appointments but attends when she has difficulty with pain or mobility.

She described her improvement in terms of being able to walk better, to pivot and turn and to move in a more regular manner, but says she is unable to do anything requiring physical exertion such as gardening or biking. Her daily routine includes walking, watching her husband's activities , watching TV and making a light meal.

[Appellant's chiropractor's] Testimony

[Appellant's chiropractor] testified on behalf of [the Appellant], with information as to the chiropractic care that he has been providing to her, sporadically, since 1981 when she had presented as a low back case with a Worker's Compensation claim. He stated that, in 1995 after her first mva, she had pain in

the cervical, thoracic and lumbar regions, accompanied by alterations to soft tissue texture in the form of hypertonicity and muscle spasms; several months later [the Appellant] displayed alterations in her posture, presenting with a hunched over position. She has good and bad days with exacerbations and remissions of symptoms. She initially had a loss of global range of motion, then a loss of segmented range of motion in the spine at C2-3, C5-6, and L5-S1. [Appellant's chiropractor] added that he had initially noticed a slight flattening in the curvature of her spine after her first mva.

At first, [the Appellant] required treatments 2-3 times per week. She would later try to manage without treatment and went without any treatment whatsoever between the following dates: January 13- March 25, 1996; April 15- May 2, 1996; August 1- August 13, 1996; December 12, 1996- January 28, 1997; April 10- May 20, 1997. From December 1, 1997 to January 1, 1998 and from February 4 to February 18, 1998 she had one treatment per week. And then from February 25 to March 30, 1998 there were no treatments whatsoever. When treatments were withdrawn she would only come on an emergency basis when she had extreme headaches and joint pain or soft tissue reactions. After the first MVA injury the trigger points in the upper thoracic area and radiating pain were close to improvement before her second motor vehicle accident.

He described his treatment plan as being based on the Disafferentation Model. This model refers to three areas; neurological, mechanical and symptomatology and is based on the structure of the central nervous system (CNS). He described the model as follows: Tissue cell receptors monitor the status of the rest of the body by afferent input which transmits the information by entering the central nervous system by pathways. This input travels up connectors in the spinal cord to the thalamus, which [Appellant's chiropractor] describes as a kind of 'thermostat' in the brain. It integrates information and output completing a reflex arc. Any alteration to the body, through trauma, is picked up by the receptors as a change in texture or function and transmitted to the brain. When an alteration in the central nervous system persists, it conducts pain more efficiently, sprouting more nerve pathways and

increasing conduction of pain resulting in long term changes. As long as there are alterations in the normal nociception or mechanoreception systems, the result will be an increase of noxious input into the CNS. By reorganization of information into the CNS there can be a reduction or elimination of the neurological deficit. As [Appellant's chiropractor] puts it: "We try to reduce or eliminate the neurological deficit by reorganizing the CNS, so that the pain-conducting pathways disappear." [Appellant's chiropractor] does not believe that 'noxious input' can be resolved without treatment, as it will not go away on its own but, rather, will worsen.

The Commission asked [Appellant's chiropractor] whether it was not an accepted tenet of his profession that, in the care of a patient, an established treatment plan is necessary and that, if a particular procedure does not appear to be working, there is an onus on the caregiver to alter the treatment or refer the patient to another practitioner or, perhaps, to another discipline altogether. [Appellant's chiropractor] replied that patients present differently on different days and an identified pattern of exacerbations and remissions is needed in order to determine that the person has reached maximum medical improvement (MMI). He stated that [the Appellant] had not become dependent on his chiropractic care but required longer treatment because of her complicating risk factors: age, gender, pre-existing degenerative changes, flattening of spinal curve, lessened elasticity in the spine, lack of awareness of oncoming accident, and loss of consciousness in the first MVA. He felt that all these factors militated in favour of very slow, gradual improvement.

After the second accident, he reported, [the Appellant] had type III pain (that is, hypersensitivity to pain). He described her as being in the remodelling phase of tissue repair, the last of three phases, wherein the original tissue is replaced with collagen which, 'though part of the healing process, has much less elasticity than the original tissue. She had presented with numerous indications of injury to her spinal column and had regressed since her second accident.

[Appellant's chiropractor] said he used passive and active exercises and a variety of procedures but [the Appellant] had not reached MMI. Her symptoms vary and there is no pattern of exacerbation and remissions that indicate MMI. When asked for objective findings, [Appellant's chiropractor] stated that vertebral subluxation complexes existed and segmental range of motion was limited, indicating damage to certain units of bone in her spine which required adjustments. He believes that a global range of motion of the body is not a reliable basis upon which to found a statement that she is symptom free. Segmental range is more important when specific joints are not moving.

On cross-examination, [Appellant's chiropractor] testified that [the Appellant's] functional deficits were made known to him by a series of questionnaires and discussions with [the Appellant's husband] & [the Appellant]. The deficits thus identified were: prolonged sitting, standing, driving her vehicle and uninterrupted sleep. He said treatments varied as needed, including analysis by way of discussion, adjustments for spinal subluxations, laser treatment for analgesic and restorative effects, and electrical stimulation. He stated that he provided treatment to cervical and thoracic areas while the physiotherapist concentrated on the lumbar region .He is of the view that the Disafferentation Model is the only one likely to produce, on a long-term basis, the reorganization of information to this patient's central nervous system. He stated that he had not made reference to [the Appellant's] questionnaires in his medical reports nor had he brought them with him as part of her chart, however they had been conducted and were available.

[Independent chiropractor's] Testimony

[Independent chiropractor], to whom [the Appellant] had been referred by MPIC for an independent chiropractic assessment, gave his opinion that, in cases where there is no sustained and marked

improvement, particularly if any risk factors such as those mentioned by [Appellant's chiropractor] are found, the patient should be referred out to some one or more other disciplines.

He noted that [Appellant's chiropractor] made no mention of questionnaires in any of his reports; it was only with their consistent use that progress could be gauged. He has patients complete them every two weeks and compares them over time. [independent chiropractor] listed questionnaires such as the Roland-Morris, the Revised Oswestry or the Neck Pain Disability Index as all being useful tools to indicate progress, or lack of it.

[Independent chiropractor] does not support the Disafferentation Model because, he says, it does not address the question of function nor does it provide any clear cut goals. He stated that he prefers the Rehabilitation Model, that tells you that when function is restored the patient can be discharged. He is of the belief that X-rays do not necessarily help to determine function, unless a person has a functional X-ray - that is to say, an X-ray taken while the patient is in flexion. X-rays that show narrowed disc space or spondylosis do not necessarily call for treatment; on the other hand, a patient whose X-rays show no such deficits may well have less range of motion and more problems than one whose X-rays do show them. As well, he believes that global range of motion is important as it addresses overall function and does not just emphasize a segmental loss.

[Independent chiropractor] said that a patient in a chronic phase, in the absence of sustained and marked improvement, should be referred to a multi-disciplinary program. He believes that [the Appellant's] discomfort with physiotherapy in the past was probably because it caused pain, especially in unsupervised home exercises. She is currently deconditioned; when in pain a patient tends to avoid exercise, then the muscles atrophy and the patient does not want to move at all. With a functional problem, treatment is needed to return the muscles to active measures and function. There are only three reasons to justify not exercising when it hurts: an infection, the incidence of a tumour,

or an instability such as a fracture or torn ligament.

The major factor here, in [independent chiropractor's] view, is that the patient has been unable to return to work despite almost 200 chiropractic and physiotherapy treatments - some 68 chiropractic adjustments alone between mid-November of 1996 and May 21, 1997. If [the Appellant] has perceived a slow but perceptible improvement, [independent chiropractor] felt that was mostly attributable to natural history.

The time for improvement by manipulation is past. Contrary to earlier beliefs, discogenic spondylosis is not 'forever'; the current and almost unanimous view of both the chiropractic and medical professions is that only with activity can the body become reconditioned. [The Appellant's] spine is not improving materially because it is not moving adequately; manipulation is not going to help that. An individual at this stage of deterioration needs to be encouraged towards activity before any long-range benefits can be achieved.

[Independent chiropractor] recommends a functional capacity evaluation, to evaluate her strengths and find out what [the Appellant] can and cannot do, to be followed by a functional restoration program to address any deficits that may be apparent. Meanwhile, he recommends discontinuance of chiropractic treatments, in order to obviate the likelihood of dependency and to give [the Appellant] the opportunity to try something different with a better likelihood of success. [Independent chiropractor] agreed that if none of his recommended modalities work and there is no measurable relief in a year, then chiropractic treatments might be her only relief. She is currently showing a slow improvement and that suggests that she will continue to improve. Even with a carefully planned functional restoration program, [the Appellant] may well experience some measure of pain (although not unbearable) in the early going, but without that she will get no better.

[Independent chiropractor's] clinical impressions were that [the Appellant] had sustained certain injuries which were attributable to the accident, namely: probable left S1 radiculopathy; aggravation of lumbar facet arthrosis and degenerative arthrosis; resolving cervical whiplash and cervical migraine. His further impression was that the Appellant was also suffering from certain problems not attributable to her mva's, namely: left carpal tunnel syndrome and left rotator cuff tendinitis with impingement. He discerned a measure of illness behaviour, in the form of a Waddell 2 sign and a positive Kummell low back and shoulder sign. [Independent chiropractor's] written report concluded by offering the following opinions and recommendations:

1. The proposed treatment plan is not reasonable and not necessary. (*We must add that it is unclear to what treatment plan [independent chiropractor] is referring, here; we presume he refers to [Appellant's chiropractor's] proposal that contemplates two adjustments per week for the next four months, to be followed by a re-assessment, although the first written mention that we have of that plan bears date June 9, 1997, in a letter that was written by [Appellant's chiropractor] in response to [independent chiropractor's] assessment.*)

2. The client has had 119 treatments and 66 physiotherapy treatments. Treatment hasn't resolved the client's cervical spine and lower back complaints which are still present. The treating practitioner should be encouraged to move from passive to more active management (i.e. de-emphasize in-office treatment, and emphasize low tech home exercise and other active measures).

3. The client requires a reconditioning program which could start with a home program of stair climbing. She is also is in need of a home course of spinal stabilization, focusing on her abdominals, multifidus, and quadratus lumborum.

4. A course of home strengthening (autoresistance or PNF) for her neck as well as proximal pelvis muscles would also be appropriate.

5. The client could be counselled in home use extension or flexion distraction, whichever she finds more comfortable/therapeutic.

6. The use of a carpal tunnel night splint (at her expense) might be helpful. Inexpensive sorbitahne orthotics (again at her expense) might be helpful as well.

7. [The Appellant] should be encouraged to stop smoking.

8. The client should consult with her MD for management of her depression. Counselling as well, may be appropriate.

9. The treating practitioner should be given 2 weeks to implement these measures.

Treatment should be reduced to once a week, with the practitioner encouraging and monitoring exercise progress, and the client discharged in 6 weeks.

10. The prognosis in regard to the client is good.

11. There appears to be no permanent impairment.

12. With regard to qualifying the injuries sustained in both accidents: it is my impression that the client had recovered 55 to 60% from her first accident just prior to her second accident. She is now slightly (approximately 10%) better than she was just prior to the second accident. (*[Independent chiropractor] does not indicate how he arrives at these impressions. We can only assume that they were gleaned from the Appellant herself, since [independent chiropractor] had not seen her before May 21, 1997*.)

[Appellant's husband's] Testimony

[Appellant's husband] testified how his wife's health had changed since her MVA in 1995. He sketched a picture of a strong- minded, athletic, independent person who, before her mva's, did things on her own. They had just built their 'dream home' in which to enjoy their activities such as cooking. He has had to do all the housework and at first provide for her movement, dressing, meals, driving her to doctors' appointments and to treatments. [The Appellant] wanted to go back to work and it was hell; she was exhausted when she came home and couldn't do anything else. Her sleep was fitful; she was exhausted going to work and attending treatments but she was determined to get better.

After [the Appellant's] 1996 mva, he testified, he had been obliged to get her up, shop for groceries, do the laundry, vacuum, move all heavier utensils on and off the stove, rearrange all the shelves in order to accommodate his wife's disabilities and do all the outside work in the garden that she had formerly done. He attended medical appointments and treatments and noticed the differences after her chiropractic treatments. [Appellant's husband] added that "after the July, 1997, incident when [Appellant's employer's doctor] said she could not return to work, it was just like they had taken the last piece of her will away because she could no longer work, even at restricted duties. She broke

down, believing she was not good for anything. She would just lie down with an ice pack and watch TV, without even giving me orders. She seemed to see [Appellant's chiropractor] almost every day."

Today, she is now being able to dress and although she is far from her pre-accident condition, she has shown slow improvements. She swept the floor on Sunday without complaints and made zucchini loaves with my help. He said "I want my wife back the way she was before".

Other Evidence.

In the interests of completeness, we should note that we were given reports from [Appellant's doctor #3] and from [text deleted], a physiatrist in [text deleted], Manitoba, to whom [Appellant's doctor #3] referred the Appellant. [Appellant's doctor #3]'s reports give a brief medical history of the Appellant and conclude that she should not return to her former employment; [Appellant's physiatrist's] last report, dated May 5th, 1998, implies some puzzlement, in that [the Appellant's] 'ligamentous perspective' does not seem to be responding to [Appellant's physiatrist's] approach, and indicates that he is referring her to the [text deleted] Clinic for bilateral L5 facet blocks since he suspects that there may be an underlying bilateral facet syndrome.

Based in large measure upon [independent chiropractor's] assessment after his examination of [the Appellant], MPIC wrote to her on May 28, 1997, to say, in part:

> .....we are prepared to consider the following:
>
> - a management plan with respect to a home stretch/strengthening plan to be implemented by your chiropractor, [text deleted];
>
> - supportive care of one (1) a week with a discharge of care within six (6) weeks.

[The Appellant] appealed from that decision by way of a request for an internal review, where her claim for reimbursement of chiropractic expenses beyond the foregoing six-week period was denied. It is from this decision she is appealing.

THE ISSUE:

The issue before us is whether MPIC was justified in terminating treatments for chiropractic care because of an absence of any objective evidence to support improvement which is both substantial and sustained.

THE LAW:

The relevant section of the MPIC Act is section 136(1), which reads as follows:

> **Reimbursement of victim for various expenses**
>
> 136(1) Subject to the regulations, the victim is entitled, to the extent that he or she is not entitled to reimbursement under The Health Services Insurance Act or any other Act, to the reimbursement of expenses incurred by the victim because of the accident for any of the following:
>
> (a) medical and paramedical care, including transportation and lodging for the purpose of receiving care; .....

In conjunction with this section of the Act, reference must be made to Section 5 of Regulation 40/94, which reads in part as follows:

> **Medical or paramedical care**
>
> 5. Subject to Sections 6 to 9, the Corporation shall pay an expense incurred by a victim, to the extent that the victim is not entitled to be reimbursed for the expense under The Health Services Insurance Act or any other Act, for the purpose of receiving medical or paramedical care in the following circumstances:
>
> (a) When care is medically required and dispensed in the province by a physician, paramedic, dentist, optometrist, chiropractor, physiotherapist, registered psychologist or athletic therapist, or is prescribed by a physician;.....

DISPOSITION:

Although we are persuaded that MPIC's decision to cease paying for [the Appellant's] chiropractic treatments was proper, we are also of the view that she should be given further, alternative assistance to regain her pre-accident condition. Her present condition, obviously not up to par, was patently caused in large measure by one or both of her two motor vehicle accidents and she is entitled to such therapeutic measures as can be made available to her.

Those measures do not, in our respectful view, include the approach recommended by [Appellant's chiropractor]. We see the Disafferentation Model that he described to us as more of a diagnostic tool, or as an explanation of how the science/art of chiropractic works, rather than as a treatment plan. Treatment of a patient with [the Appellant's] complaints is intended to restore function; [Appellant's chiropractor's] approach seems to be directed more towards the removal of pain. The two are by no means the same and, perhaps even more importantly in this case, there is little evidence of the sustained and measurable, material improvement achieved by following the Disafferentation Model. One of the principle concerns of this model is the apparent lack of a goal for restoration of function. [Appellant's chiropractor] was not able to provide an estimate of when his treatments might reasonably be expected to restore function and be concluded.

We recognize that [the Appellant] does have complicating risk factors such as age, gender, pre-existing degenerative changes and flattening of the spinal curve, however she had been restored to near pre-accident condition prior to her second mva and, as well, she was able to return to work after that second mva. Both [Appellant's husband] and [the Appellant] indicated that there was a slight improvement in the Appellant's condition, but in our view her improvement was no greater than that

which would have been achieved by natural history.

It is apparent that we are dealing with two distinctly different models of chiropractic treatment . The available literature persuades us that, at least in the present instance, the position advanced by [independent chiropractor] is the desirable one. The Clinical Guidelines for Chiropractic Care in Canada, adopted by the chiropractic profession here in Manitoba have a clearly articulated viewpoint. " The primary goal is to provide sufficient care to restore health, maintain it, and prevent the recurrence of injury and illness. Used appropriately, chiropractic care is capable of reducing pain, improving function and promoting health. Used inappropriately, it can become a passive treatment approach promoting patient dependency (Chapman-Smith 1992)." The prevailing literature also makes clear that if, in patient care, after objective and subjective reassessments a patient has not achieved a marked and sustained improvement within a reasonable time, the caregiver should amend the treatment, discharge the patient or refer the patient. If there is little demonstrable, additional progress after two months the patient should be discharged and presumed to have achieved maximum therapeutic benefit.

[Independent chiropractor] in his independent assessment looked for risk factors for chronicity. With these noted risk factors as well as [the Appellant's] personal complicating factors he recommended that there is justification for extended treatment of another modality. At the time of the independent assessment [independent chiropractor] did not recommend cutting off treatment but, rather, suggested a shift in the focus in her treatment toward active care which would involve stretching and strengthening.

We have no hesitation in finding MPIC justified in discontinuing chiropractic treatment at the time and in the manner that it did. However, it is regrettable that MPIC does not appear to have followed the recommendation of its Internal Review Officer who, in his decision letter dated November 6, 1997, directed the adjuster to follow up with [independent chiropractor] and the Appellant regarding another

course of management, which would presumably have included a functional capacity evaluation and, thereafter, a functional restoration program.

Therefore, while confirming the decision of MPIC's Acting Review Officer of November 6, 1997, in the exercise of our jurisdiction under Section 184(1)(b) of the MPIC Act, we direct that MPIC's Case Management team refer [the Appellant] to an appropriate agency for a functional capacity evaluation, to be followed by such functional restoration program as may be recommended by that agency.

Dated at Winnipeg this 8 day of October 1998.

J. F. REEH TAYLOR, Q.C.

CHARLES T. BIRT, Q.C.

LILA GOODSPEED