Manitoba

Automobile Injury Compensation Appeal Commission

IN THE MATTER OF an Appeal by [the Appellant]
AICAC File No.: AC-13-016

PANEL:	**Ms Laura Diamond, Chairperson** **Ms Janet Frohlich** **Mr. Guy Joubert**
APPEARANCES:	**The Appellant, [text deleted], was represented by Ms Patricia Lesavage;** **Manitoba Public Insurance Corporation ('MPIC') was represented by Mr. Anthony Lafontaine Guerra.**
HEARING DATE:	**April 9, 10, 11, 15, 16 and 17, 2019.**
ISSUE(S):	**Whether the Appellant is entitled to Personal Injury Protection Plan benefits: (whether a causal relationship can be established between the current signs/symptoms and the motor vehicle accident of Jan. 29, 2009).**
RELEVANT SECTIONS:	**Section 70(1) of The Manitoba Public Insurance Corporation Act ('MPIC Act').**

Reasons For Decision

<u>Background:</u>

The Appellant was injured in a motor vehicle accident (MVA) on January 29, 2009. As a result of the accident, she sustained soft tissue injuries to the neck and back and an injury to the left foot. At the time of the accident she was employed as a registered nurse on a full time basis with the [Hospital].

The Appellant attended at the [sports medicine rehabilitation centre] the day after the MVA and was diagnosed with an avulsion fracture to the left lateral calcaneal joint and torn ligaments. Later radiological reviews questioned whether a fracture had actually occurred. However, the Appellant was prescribed a walking boot and medication.

The Appellant received physiotherapy and chiropractic treatment as well as orthotics. She received treatment from her family physician who also referred her for a neurological assessment.

The Appellant received Income Replacement Indemnity (IRI) benefits from MPIC. The Appellant also began a rehabilitation and graduated return to work program. She then reported being involved in a fall that resulted in a concussion. She received later diagnoses of chronic pain syndrome, cervical spine injury and post concussion syndrome. She was never able to return to full time work as a registered nurse and retired.

MPIC's Health Care Services team reviewed her pre-existing medical conditions (which included insulin dependant diabetes) as well as the reports from her caregivers and rehabilitation clinic. Her case manager ended her IRI benefits in July of 2011, without a written decision letter. She was later provided with a case manager's decision dated May 17, 2012 ending her entitlement to Personal Injury Protection Plan (PIPP) benefits, as a causal relationship could not be established between her current symptoms and the MVA.

The Appellant sought an interval review of this decision and, on November 15, 2012, an Internal Review Officer (IRO) for MPIC concluded that the medical evidence did not support a causal relationship between her ongoing symptoms and the MVA. However, she concluded that the

termination of the Appellant's IRI benefits should not be retroactive, (due to the absence of a proper written decision letter in July 2011). Therefore, the Appellant received IRI benefits until the date of her retirement of January 31, 2012 and funding of her medical expenses until the date of the decision of May 17, 2012.

It is from this decision of the IRO that the Appellant has now appealed.

Issue:

The issue for the Commission is whether the Appellant's current signs and symptoms were caused by the MVA. Following an extensive review of the documentary materials and the oral testimony and submissions heard over six days of hearings the panel finds that the Appellant's current signs and symptoms were not caused by the MVA and she is not entitled to further benefits.

The Appeal Hearing:

The appeal hearing took place over the course of six days. The panel heard evidence from the Appellant, her friend, her massage therapist and chiropractor, as well as evidence from her general practitioner. MPIC presented evidence from MPIC's medical and chiropractic consultants.

At the outset of the hearing, counsel for the Appellant indicated her intention to establish a causal relationship between the Appellant's current signs and symptoms and the life changing MVA. The Appellant had a strong work ethic as a highly skilled competent nurse who never abused her sick time. She had a gregarious social personality, was involved positively with friends and family and enjoyed racquetball, biking, golf and walking at her cabin. The injuries

resulting from the MVA were not merely a matter of subjective behaviour or self-limiting reporting. The evidence of the Appellant and the expert witnesses would establish that the Appellant's pain (foot, neck and headaches) and cognitive difficulties all stem for the MVA and forced her to take early retirement.

Counsel for MPIC took the position that a causal relationship between the Appellant's continuing symptoms and the MVA could not be established on a balance of probabilities. The Appellant's injuries from the MVA had healed from a functional standpoint. They were not the kind of injuries which would have led to a chronic physical or psychological condition. Rather, it is only the Appellant's subjective reports which are left. While MPIC sympathizes that the Appellant's injuries may have been painful at the outset, there is nothing resulting from the MVA that stopped her return to work. Pre-existing medical conditions such as diabetes, degenerative changes, age, and lifestyle may have contributed, but the Appellant was not able to demonstrate a true level of function because of her self-limiting and subjective reports of pain and excuses for not fully participating in return to work programs. The forensic reviews and expert evidence to be heard in the appeal support the decision of the IRO.

Evidence:

The panel reviewed both documentary and oral testimony at the appeal hearing. The following is a summary of the evidence.

The Appellant

The Appellant provided evidence at the hearing, through direct testimony and a lengthy cross-examination. She described her long work history at her demanding job as a ward hospital nurse, along with ongoing continuing education and excellence awards.

She then described the MVA of January 29, 2009 and the aftermath, which included left foot pain and swelling. She attended at [sports medicine rehabilitation centre] the next day, was sent for x-rays and saw [Appellant's general practitioner #1]. He examined her, reviewed the x-rays and told her that she had an avulsion fracture of the calcaneal cuboid, torn ligaments and whiplash. She was prescribed a calf boot for 61 days. She was later sent to [footwear store] to obtain orthotics and started physiotherapy. From approximately the end of March through the fall, she had difficulty with walking, leg swelling, limited range of motion and tender areas.

In late June 2009 she began to return to work on a supernumerary basis for two hours a day, three days a week. She described this as being extremely difficult with a lot of pain in her left foot and around the ankle and talus bone. She developed acute pain in her right leg which she believed was because she was compensating for the pain in her left foot. As she increased her hours at work she had more difficulty with pain and swelling in her foot and right leg as well as decreases in range of motion. In October, she developed an acute tendinitis inflammation and [Appellant's general practitioner #2], who she was now seeing as a general practitioner, suspended her return to work program for two weeks while this settled down.

The Appellant described her difficulties in returning to work duties with increasing symptoms such as pain and swelling. At this point, her cervical symptoms became aggravated with neck pain and strain associated with her duties. This led to headaches. She had trouble sleeping.

So in January 2010 [Appellant's general practitioner #2] again suspended her return to work program and sent her to an orthopedic surgeon, [text deleted]. A bone scan showed inflammatory changes. A visit to a neurologist for nerve conduction studies showed that she had

borderline normal/abnormal results. She indicated that she had good blood sugar control, which was well documented, as she visited her endocrinologist every six months.

She began to see [text deleted], physiatrist at [rehabilitation facility #1], who trialed different pain medications. She reported many side effects from these medications.

The Appellant described attending a reconditioning and work hardening program at [rehabilitation facility #2] but struggling with some of the exercises and finding stairs difficult. Her cervical symptoms and headaches increased. She tried a foot brace prescribed by [Appellant's physiatrist #1].

The Appellant participated in a Functional Capacity Evaluation (FCE) program and stated she produced maximum effort, but was still not able to work 12-hour shifts.

As her work hours increased, her symptoms were exacerbated. Then, on May 31, 2011, she fell down a flight of thirteen stairs in front of her house. [Appellant's general practitioner #2] stopped her return to work program and she had an MRI to rule out a brain bleed. She saw a neurologist again to address post-concussion syndrome, as she suffered from headaches, light sensitivity, noise sensitivity, motion sickness, memory problems, mixing up numbers and letters and difficulty keeping track of her pain medication. Her family noticed problems with her memory. She was no longer able to help her son in his business (as she used to do) as she had poor judgement. Her mental math, which used to be very sharp, was now very bad.

When MPIC terminated her IRI and expense entitlements, she felt she had to take her retirement because she needed her pension benefits. Therefore, she retired in January 2012.

She described her days now as dictated by pain, headaches, fatigue and cognitive dysfunction. She continued on her own with chiropractic and massage therapy treatments. She is no longer able to enjoy being socially active or travelling with her family even to her cabin. She cannot participate in sports such as racquetball or basketball as she used to. She felt very strongly that the MVA caused life-altering injuries for her.

On cross-examination, the Appellant acknowledged her history of diabetes as well as a prior history of hypertension, sleep apnea and transitional cell bladder papilloma.

In reviewing the circumstance of the MVA she acknowledged that it occurred in a parking lot at a speed of under twenty kilometers per hour, that she was wearing a seatbelt, saw the oncoming truck approaching and was prepared for a collision. She did not recall where her left foot was positioned at the time of the impact but confirmed she felt pain in her left foot immediately following the MVA which was “like a severe ache and throbbing”. She confirmed that she did not feel any other pain or identify any other injuries immediately following. She did not lose consciousness or strike her head, although both airbags were deployed.

Although [Appellant’s general practitioner #1]’s report indicated that he only treated her for her left foot injury, the Appellant specifically recalled him examining her neck and diagnosing her with a whiplash. The Appellant admitted that when she saw [Appellant’s general practitioner #1] the day after the MVA she saw him for her ankle and foot pain and not for a blow to the head or any abrasions from the MVA.

The Appellant discussed her treatment by a chiropractor [Appellant's chiropractor #1] and her first physiotherapist [Appellant's physiotherapist #1]. She denied experiencing any impatience with [Appellant's general practitioner #1] treating her injury as a minor one, and did not recall expressing such dissatisfaction to her case manager, as recorded in a file note. She did acknowledge that she and [Appellant's general practitioner #1] had a difference of opinion over her treatment, without explaining what that was.

The Appellant stated that she stopped seeing the physiotherapist, [Appellant's physiotherapist #1], because she was in a reconditioning program and thought she would try a different physiotherapist. She then saw physiotherapist [Appellant's physiotherapist #2] for her neck, foot and back pain. Although she was aware that physiotherapist [Appellant's physiotherapist #1] and [Appellant's general practitioner #2] did not agree on her course of treatment (with [Appellant's physiotherapist #1] objecting to the breaks in her return to work program), she said this was not the reason she did not return to [Appellant's physiotherapist #1].

She disagreed with reports from physiotherapist [Appellant's physiotherapist #1], including a discharge report, that indicated the Appellant's symptoms had virtually resolved. She maintained that her back pain was better but not her foot pain.

She indicated that she moved from chiropractor [Appellant's chiropractor #1] to [Appellant's chiropractor #2] in search of the craniosacral work that [Appellant's chiropractor #2] does.

The Appellant explained that her symptoms are "easily aggravated". She understood that [Appellant's general practitioner #2] diagnosed chronic pain syndrome, which to her meant that

her pain had been problematic for a long time and was chronic, in that it was not going to go away in days or weeks.

The Appellant was asked several questions regarding medications which she took including Tramacet, Gabapentin, Amitriptyline and Morphine. She confirmed that these made her very drowsy and confused and were not effective at controlling her pain.

She maintained that her falls did not relate to any of this medication but rather to the pain in her foot which caused her to collapse. Her foot would “give out”. She believed she could have post-traumatic arthritis in her foot.

[Text Deleted]

[text deleted] provided a written character reference and testified at the appeal hearing. She was a nursing school graduate who had worked at [hospital], and on the burn unit with the Appellant, for 21 years. She described the complex work of that unit and the amount of time she had spent with the Appellant. She described her as an extremely knowledgeable and empathetic nurse, highly skilled, calm and competent with a strong work ethic. She also described her personality before the MVA as being vibrant and bigger than life.

She then compared this to the Appellant’s presentation after the MVA which she indicated had impacted her physically, mentally and emotionally. She indicated that the Appellant’s life is now controlled by her pain and that she is forgetful, easily distracted and confused. She has become introverted and reclusive.

Massage Therapist

The Appellant's massage therapist, [text deleted], provided a report dated January 15, 2018. This indicated that she had been seeing the Appellant since May 28, 2010, beginning with attempts to reduce pain in her left foot. She testified she first met the Appellant in May 2010 and did not know her before or during the period immediately following the MVA. She assessed the Appellant's gait, which she found to be right side heavy and consistent with point tenderness in the calcaneus cuboid. She also diagnosed chronic whiplash symptoms and noted the Appellant's headaches which followed her fall. She applied gentle cranial therapy and recommended that the Appellant see the chiropractor, [Appellant's chiropractor #2], who she described as using gentle techniques including the CATS (Cranial Adjusting Turner Style) method.

That relief was temporary with the pain always returning. By 2011, treatments began to include neck and shoulder work to try and relieve headaches and tension but the Appellant did not improve or even stabilize. Her proprioception worsened, muscle spasms seemed more frequent, she began to stumble and suffer from falls and her quality of life suffered because of it. Long-term relief could not be reached.

The massage therapist also noted the Appellant's cognitive issues, which seemed to get worse after her fall in May 2011.

<u>Chiropractor</u>

The Appellant's chiropractor, [Appellant's chiropractor #2], provided a report dated April 16, 2013, and testified at the appeal hearing. She indicated that after treatment the Appellant would experience a few good days of relief. She explained that a misalignment of cranial bones accounted for the Appellant's symptoms and that this was due to the MVA. She indicated that it

does not take a lot of force for this to occur, but admitted that this was also possible in falls and that the cranial misalignment could affect her cognition.

The chiropractor attributed the Appellant's falls to lack of balance and instability in her foot due to misalignment.

As stated in her report of April 16, 2013, [Appellant's chiropractor #2] was of the view that:

> … On a balance of probabilities, it is my opinion that there is a causal connection between [the Appellant]'s ongoing symptoms and her MVA of January 29th, 2009. Her life certainly has NOT been the same since.

[Appellant's general practitioner #1]

[Appellant's general practitioner #1] saw the Appellant following the MVA and provided reports dated February 15, 2009, April 1, 2009, January 12, 2015 and November 9, 2017. He did not testify at the appeal hearing.

His initial Primary Health Care Report indicated a clinical diagnosis of small avulsion fracture of the calcaneal cuboid joint and sprain. A Subsequent Health Care Report noted pain in the left lateral foot as well as a tender lateral tarsal-metatarsal joint. Torn ligaments were added to the clinical diagnosis of the small avulsion fracture, indicating that the Appellant was using a boot brace and slowly improving.

In a subsequent narrative report dated January 12, 2015, he confirmed that he treated the Appellant only for her left foot injury and confirmed that based upon his interpretation of the

x-ray there likely was a small avulsion fracture present as well as torn ligaments of her lateral foot. These would have made it difficult for the Appellant to mobilize well and maintain a good balance. He noted:

> … The average recovery time for this kind of injury would be 6-8 weeks. However, sometimes the pain can last a lot longer…

He recognized that the Appellant had a history of type II diabetes but could not comment on how this would affect her MVA injuries. He went on to state:

> … In terms of prognosis for recovery, according to my chart records, on June 10, 2009, the patient said her foot was better but I had not seen her since so I had assumed she had made a good recovery…

In a report dated November 9, 2017, [Appellant's general practitioner #1] described the initial fracture injury as well as x-rays showing the Appellant's pre-existing osteoarthritis of the tarsal joint. He concluded:

> … I do believe that some of the pt's pain, which is currently more in the lateral ankle and foot, is related to her MVA injury. She has post-traumatic lateral calcaneal cuboid joint pain and lateral ligamentous ankle pain. Also her general ankle pain is likely also partly caused by the medial OCD which may be post-traumatic and related to the MVA. She does also have pain related to the pre-existing tarsal OA.

<u>Physiotherapist [text deleted]</u>

[Appellant's physiotherapist #1] provided an Initial Therapy Report dated April 1, 2009 and Return to Work/Modified Duty Forms to the case manager. There are also case manager's file notes and messages to the case manager from [Appellant's physiotherapist #1], as well as a Discharge Report dated November 24, 2009 and a Subsequent Therapy Report dated March 9, 2010. [Appellant's physiotherapist #1] was focussing on a gradual return to work plan which would allow the Appellant to increase her shifts by one hour every two weeks and introduce consecutive days, increasing to the 12-hour shift. There was discussion, both in the notes on file

and in the oral testimony of witnesses, regarding [Appellant's physiotherapist #1]'s frustration with what she perceived as the derailing of these back to work efforts by the Appellant, as supported by [Appellant's general practitioner #2]. It was suggested to the Appellant that this led to her rejection of [Appellant's physiotherapist #1] as a treatment provider when she decided to independently pursue physiotherapy treatment from [Appellant's physiotherapist #2]. However, [Appellant's general practitioner #2] testified that he was not aware of [Appellant's physiotherapist #1]'s frustration which he would have been happy to discuss with her.

[Appellant's Physiotherapist #2]

[Appellant's physiotherapist #2] provided physiotherapy reports dated August 9, 2011, June 5, 2014, January 2018 and March 6, 2019. He described his treatment of the Appellant, and some modest success with the Appellant's return to work program, up to six hours of some patient care. However, subsequent cognitive issues raised doubt for similar success. The report of January 2018 confirmed that the patient's original and present movement, symptoms and areas of pain and stiffness remained the same from the original assessment.

A report dated March 6, 2019 set out several areas of injuries from the MVA:

- The neck range of motion was markedly reduced and painful, both actively and passively
- The patient complained of constant headaches
- The left ankle's lateral ligaments were painful to palpitation and stress
- [The Appellant] also reported cognitive issues (memory, word finding lapses, etc.)
- Balance issues were also an issue with a number of stumbles and falls. The patient attributes these to her ankle problems.

He concluded that:

> … After years of treatment, it is probably safe to assume that [the Appellant]'s condition is chronic and constant.

> Her status prior the MVA was a functioning nurse and homemaker. Since her MVA, [the Appellant] has not been able to regain this functional level.

[Appellant's general practitioner #2]

[Appellant's general practitioner #2] is the Appellant's general practitioner. He provided several reports and chart notes for the indexed file as well as oral testimony at the appeal hearing. The Appellant had been a patient of [Appellant's general practitioner #2] years prior to the MVA and then returned to him in June of 2009. He described this as a "meet and greet" where he would take her history and agree to take her on as a new patient. At that time, he was made aware of the MVA and that she was being treated for it by [Appellant's general practitioner #1]. According to his evidence it was only later that he discovered that she no longer intended to see [Appellant's general practitioner #1] for her motor vehicle related concerns and that [Appellant's general practitioner #2] would now be responsible for that.

On cross-examination, [Appellant's general practitioner #2] learned that the Appellant had felt that [Appellant's general practitioner #1] was very impatient with her because he treated her ankle injuries as a minor injury, telling her that she was ready to begin physiotherapy and would be able to return to work by April 27, 2009. The Appellant was upset because she felt this dismissed her complaints of significant pain and that she would not be able to work 12-hour shifts at the hospital. [Appellant's general practitioner #2] advised he was not aware of this.

[Appellant's general practitioner #2] documented and continued to treat the Appellant throughout her struggles with the rehabilitation and return to work program. He continued to monitor her diabetes and sent her to various specialists by referral.

[Appellant's general practitioner #2] was firmly of the view that in spite of the previous assertion by MPIC's medical consultant, [text deleted], the Appellant's symptoms were not caused by diabetic neuropathy. This was confirmed by follow up reports he received from the Appellant's endocrinologist and his continued monitoring of her diabetic condition. Her sugars were under good control and she managed the condition well.

In his view, the Appellant's falls and cognitive problems and falls were a result of the medication she was taking for her pain. He did not link this, on a balance of probabilities, to causes such as pain or a misaligned gait.

[Appellant's general practitioner #2] was of the view that the Appellant had developed a "chronic pain syndrome", defining that as pain from the MVA that does not go away. This was because she did not have this pain before the MVA. It is pain that lasts, he explained, wherever it is, although he did not approach it as a syndrome or a psychological syndrome.

It was [Appellant's general practitioner #2]'s opinion, having relied upon feedback received from [text deleted], (physiatrist) and [text deleted] (psychologist) that the Appellant would never really be able to go back to work as a 12-hour ward duty nurse, at her age.

<u>[Appellant's Orthopedic Surgeon]</u>

The Appellant was referred to [text deleted], orthopaedic surgeon, by [Appellant's general practitioner #2]. He did radiological investigation, including a bone scan and provided a report dated January 15, 2010. The bone scan showed inflammatory reaction at the metatarsal tarsal articulation, but in the right foot, and not the left foot that was the source of the Appellant's complaints after the accident.

[Appellant's Neurologist]

[Appellant's general practitioner #2] also referred the Appellant to [text deleted], neurologist. He provided a report dated January 21, 2010. He described the MVA resulting in a fracture of the Appellant's calcaneus and her continuing foot and leg pain and stiffness, as well as stiffness in her neck and back pain.

He stated:

> … Examination of her limbs showed normal power with normal distal muscle bulk. Tone and coordination were intact and reflexes intact except for an absent left ankle jerk. Her toes were downgoing to plantar stimulation. There was no sensory deficit for pinprick. Vibration sense was about 10 seconds in the toes bilaterally.
>
> The nerve conduction studies are borderline normal or abnormal depending on your point of view. The findings would be compatible with a mild diabetic sensory neuropathy….

On August 3, 2011, [Appellant's neurosurgeon] provided a medical report following physical examination. He found that she walked slowly and limped, favouring her left leg. He concluded that she was generally orientated to time and place, noting:

> … I regard her symptoms as post traumatic in nature. Certainly the foot issues are post traumatic and her cognitive issues, headache, etc. are likely related to a post concussion syndrome from her fall in May of this year. You have arranged for a CT scan of the brain which has not shown any obvious pathologies and I am not inclined to any further investigations at this point…

[Appellant's physiatrist #1]:

[Appellant's general practitioner #2] also referred the Appellant to the physiatrist, [text deleted]. He provided a report dated March 30, 2010 and subsequent letters and reports dated April 20,

2010, September 21, 2010, October 12, 2010, November 9, 2010, November 30, 2010, December 14, 2010 and January 25, 2011.

On April 20, 2010, [Appellant's physiatrist #1] explained that osteoarthritis in the Appellant's left mid foot would fit with her areas of complaints of pain. He described her confusion on the drug Tramacet, leading him to favour the use of short-acting narcotics, which he felt might make the difference between getting her back to work and not getting back to work.

Later reports also addressed some tenderness in her spine along with the ankle joint on the medial and lateral side. He indicated that she walked well but as it had been several months since she had not returned to work, he felt that prognosis was guarded. He continued to explore other medications, including narcotics for pain control. He described trials with Morphine and Hydromorphone, continuing pain and difficulties with the work hardening program. He indicated that she looked depressed and would dwell on the description of her pain. He noted chronic pain behaviour. A fentanyl patch was tried, as well as acupuncture and massage. He believed that she would be using Lyrica, Tramacet and Amitriptyline to control her pain, indefinitely.

[Appellant's general practitioner #2], in spite of expressing significant concerns and doubts regarding this use of narcotics and other medications, continued to rely on [Appellant's physiatrist]'s opinions, particularly in regard to his assessment that the Appellant's possible prognosis for return to work was guarded.

<u>[Appellant's Psychologist]</u>

[text deleted], a clinical and neuropsychologist, provided a report dated March 9, 2015. He found the Appellant mildly dysphoric but able to comprehend questions asked of her and respond appropriately without evidence of significant difficulty. He concluded that the Appellant suffered from a mild level of dysphoria or depression but provided no further diagnosis. He suggested that she try to keep as mentally active as possible and consider counselling to talk about her current situation and feelings.

[Rehabilitation Facility #2]

The Appellant underwent a facilitated collaborative rehabilitation assessment and rehabilitation program at [rehabilitation facility #2]. Reports were provided by [Appellant's physiatrist #2] (physiatrist) as well as from other therapists at that facility. The program was extended at various points, but was not successful. Concerns were raised regarding self-limiting behaviour at certain points, although not by all therapists. Missed appointments were also noted. The final discharge report dated February 9, 2011 indicated that the Appellant had demonstrated minimal progress with her reconditioning program and minimal functional gains. She continued to report severe pain levels and to score high in her perceived levels of disability. Although she indicated that there were times she was unable to take her pain medication before attending the clinic (so that she could drive) she was still noted to have frequent pauses and have difficulty searching for appropriate words. No other cognitive issues were observed while she attended the clinic. Her caregivers found it difficult to explain why the Appellant did not progress functionally as a result of her reconditioning program and the treatment received at the clinic or to explain why her symptoms would be getting worse, given the medical findings at the time of her examination by [Appellant's physiatrist #2] and the physiotherapist.

> … At this time, it is our opinion, that given the diagnosis at the time of her motor vehicle accident, her medical findings while attending our clinic and the fact that she is now 2 years post accident, she is fit to participate in a return to work

> program, with regard to the injuries she sustained in her motor vehicle accident of January 29, 2009.
>
> [The Appellant] was discharged February 3, 2011, with a home program…

Health Care Services Chiropractic Consultant – [text deleted]

[MPIC's chiropractic consultant, health care service] provided forensic Health Care Service reports dated April 19, 2012 and September 13, 2018. He also testified at the appeal hearing and commented regarding the evidence of [text deleted], the Appellant's chiropractor.

His first report commented upon the MPIC Health Care Medical Consultant's opinion that the Appellant had sustained a cervical musculotendinous strain as well as left foot strain or sprain.

In regard to the Appellant's chiropractor's reports of cranial misalignment as a diagnosis, he noted:

> … Presumably, this refers to misalignment of the cranial bones resulting in an osseous dysrelationship. There is no evidence on file of head or cranial vault trauma that would probably cause bony skull injury, and the cranial bones are held together by the cranial sutures, which are essentially immobile. There is no objective evidence that any cranial misalignment found by the chiropractor subjectively relates to the effects of the motor vehicle accident.
>
> The chiropractor has also reported ankle bone "*subluxation*" and ligament weakness post fracture. The claimant suffered a soft tissue injury to the left foot. The current chiropractic diagnosis would not, in my opinion, relate to injuries sustained in the motor vehicle accident.
>
> In my opinion, chiropractic treatment is not required in relation to injuries sustained in the motor vehicle accident.

[MPIC's chiropractic consultant]'s testimony at the hearing confirmed this opinion.

Health Care Services Medical Consultant – [text deleted]

[MPI medical consultant, health care service] provided reports dated January 4, 2012, September

12, 2013, March 16, 2015, March 26, 2015, February 26, 2018 and September 13, 2018. He also testified at the appeal hearing. He reviewed the Appellant's x-ray films in detail for the panel.

[MPIC's medical consultant] acknowledged that some of his earlier reports had attributed the Appellant's problems with pain in her foot to a diabetic neuropathy. However, during his testimony he ultimately conceded that although he had originally suspected this, given the evidence from [Appellant's general practitioner #2] and the investigations [Appellant's general practitioner #2] had performed, through the Appellant's endocrinologist and other testing, this was not correct. The Appellant had not suffered from a diabetic neuropathy.

Based on radiological and other evidence, [MPIC's medical consultant] had serious questions regarding [Appellant's general practitioner #1]'s diagnosis of an avulsion fracture. His testimony ultimately indicated that he could see how [Appellant's general practitioner #1] might have been suspicious of a fracture at the time, even though the subsequent radiology reports didn't seem to support that. In [MPIC's medical consultant]'s view, the Appellant had a ligament injury and a possible avulsion fracture that he described as being like a moderate sprain. It was not a significant or major injury. Typically, this should have gotten better within four to six weeks. Although he recognized that it could sometimes take longer, he did not agree that it should have taken until 2012 or even 2019 to get better.

In hindsight, [MPIC's medical consultant] did recognize some degenerative, likely pre-existing issues with the Appellant's foot, however, his basic focus was on the lack of objective evidence regarding the Appellant's apparently worsening condition. There was little evidence of impairment to start with, he opined, and he supported the assumption that time and therapy would help and assist her in becoming more functional. There were no clinical findings

indicating her condition was deteriorating or would prevent her from progressing. A review of the [rehabilitation facility #2] reports showed that there were no findings that there was anything seriously wrong with the Appellant and he agreed with their recommendation of getting her back to work. He recognized that the longer one is off, the harder it is to get back to work. He was also concerned about the narcotics prescribed for her and their possible effect on her ability to return to nursing duties.

In reviewing the Functional Capacity Evaluation prepared regarding her nursing job, [MPIC's medical consultant] concluded that nursing was not a hard job. His review of the Appellant's work hardening and back to work programs, as well as the physiotherapy she received, led him to the conclusion that her subjective complaints were not reliable and did not correlate with her injury. Ten years later the Appellant was still disabled, yet there was no radiological or clinical basis which would explain why.

Submissions:

Submission for the Appellant

The Appellant provided both a binder containing a written submission and oral submissions in summary. The panel noted that this binder contained many photographs provided by the Appellant which were not in evidence and therefore have been disregarded by the panel.

The Appellant relied upon her own evidence and the evidence of her friend to show that before the MVA she was a hard worker, never taking sick time, working many jobs and helping her son in his business. She received nursing awards of excellence and pursued continuing education. She was physically and socially active, travelling and enjoying her lake cabin.

The MVA and the immediately resulting foot pain ended all this. Counsel submitted that there

was much debate about whether there had been a fracture, but noted that [MPIC's medical consultant] admitted that this was possible and that [Appellant's general practitioner #1] stood by this initial diagnosis in all of his reports. In any event, it was agreed that there was a torn ligament and that the Appellant was placed in a walking boot for some time period. The pain in her left foot continued long after the MVA. During her first return to work program between June and November 2009, the Appellant experienced many difficulties and was ultimately prescribed Tramacet. This caused difficulty for driving and other things. The [rehabilitation facility #2] program was ultimately not successful.

The evidence from the Appellant's massage therapist described the tightness and pain the Appellant experienced and the limited relief she received for it.

Counsel also reviewed a particularly bad fall which the Appellant had suffered, hitting her head, on May 31, 2011. She was seen by [Appellant's general practitioner #2] for an assessment the next day. Counsel submitted that since the MVA, the Appellant's foot had been causing her troubles especially when walking on stairs. She had trouble with proprioception. After the fall this became even more difficult for her. She began seeking therapy from chiropractor [Appellant's chiropractor #2] who used activator treatments, receptive toner trigger therapy and cranial adjustment therapy. This was described as a gentler approach, and counsel submitted that even [text deleted], MPIC's Health Care Services chiropractic consultant had acknowledged that some patients can't handle an aggressive approach and needed gentler therapy. [Appellant's chiropractor #2] provided research to support her theories and technique. The Appellant, it was submitted, was being protective of her body in following this approach. That is not self-limiting, it was submitted. Rather, the Appellant showed initiative in trying anything that would help herself in spite of her non-improving chronic pain.

Counsel for the Appellant addressed the issue of subjective pain complaints. It was submitted that it was the responsibility of health care professionals to first ask a patient how they were feeling. Subjective complaints need to be evaluated, it was submitted, and are an important part of any assessment.

It was submitted that the Appellant was not self-limiting and that if the physiotherapist [Appellant's physiotherapist #1] had concerns about the Appellant's pauses in her return to work schedule, supported by [Appellant's general practitioner #2], she should have called [Appellant's general practitioner #2] to suggest them and had not.

[Appellant's general practitioner #2]'s concerns about her medication were reviewed as well as the cognitive difficulty that had arisen for the Appellant. It was submitted that she was now "Alzheimer like" and socially isolated. The Appellant's life had changed. It was submitted that the witnesses, testimony and evidence established a causal relationship between these current signs and symptoms of the Appellant and the MVA of January 29, 2009.

The Appellant referred to previous cases of the Commission in AC-14-023 and AC-00-107 for support in establishing a causal relationship between an MVA and the Appellant's inability to return to work as a result.

Remedy

The Appellant seeks coverage for medical therapy (past and future) including chiropractic, massage, acupuncture, pressure stockings and orthotic shoes as well as permanent impairments for injuries to her left foot, cognitive impairments, headaches and neck pain.

Submission for MPIC:

Counsel for MPIC provided written and oral submissions. Both recognized that the Commission has had occasion to recognize chronic pain as entitling one to receive benefits (AC-03-157). However, such cases involve an analysis of objective evidence to support the symptoms and subjective pain complaints reported.

Counsel submitted that where there is no objective evidence to corroborate pain reports, MPIC must assess the credibility of the claimant by looking at the consistency of their reports, their overall behaviour and the opinions expressed by the professionals treating them. In this case, MPIC submitted that there was no objective evidence to corroborate the subjective reports by the Appellant and that the Appellant has shown that she is not a credible witness.

The MVA was not particularly severe, occurring at a low rate of speed with low impact force. The chief complaints of the Appellant following the MVA were a left foot and ankle injury and a stiff sore neck, followed by reports of back pain.

Foot and Ankle

Counsel's examination of objective evidence for the Appellant's pain covered the question of whether the Appellant had suffered an avulsion fracture of the calcaneal joint in the MVA. The evidence of [Appellant's general practitioner #1] clearly supported this, while, following further radiological review, [MPIC's medical consultant] did not believe this to be the case. However, regardless of whether the Appellant suffered a fracture or a sprain/strain, [MPIC's medical consultant] testified that the normal healing course for this type of injury would be approximately six weeks and that he would not have expected it to result in a permanent impairment of function. In fact, evidence from [Appellant's general practitioner #1] agreed with

this assessment, leading to the Appellant's frustration with [Appellant's general practitioner #1] telling her she had a very minor injury. [Appellant's general practitioner #1] confirmed that the average recovery time for a small avulsion fracture would be six to eight weeks and that the Appellant had expressed to him her foot was better as of June 10, 2009.

When the Appellant continued to report pain and swelling, doctors carried out investigations in attempts to find an explanation. None of the investigations revealed anything related to the MVA that could explain the Appellant's pain. There were signs of plantarian calcaneal spurs and extensive calcification which clearly pre-dated the MVA and, curiously, a bone scan suggested greater issues with the right foot than the left foot she complained about. [Appellant's physiatrist #1] noted a better gait without shoes and osteoarthritis in her left foot.

All of the clinical notes showing reports of tenderness were based on self-reports and not objective findings. Further, although the Appellant often reported experiencing swelling, there was little evidence of observed swelling and there was some evidence that her ankle and foot appeared normal upon examination.

Neck and Back

Although the Appellant testified that [Appellant's general practitioner #1] examined her neck, there was no evidence on the file that this had occurred. [Appellant's general practitioner #1]'s Primary Health Care report did not identify injuries to the neck area and he appears to have examined the left foot only. The first report of neck pain was not until March 27, 2009 when a chiropractor, [Appellant's chiropractor #1], examined the Appellant and made findings consistent with a whiplash-associated disorder, although not requesting more advanced Track II care.

The physiotherapist [Appellant's physiotherapist #1] examined the Appellant on March 31, 2009 but made reference only to a resolving c-sprain. Her notes were that low back and cervical symptoms were "virtually resolved" at the time of discharge from her care on November 24, 2009.

When the Appellant reported to [Appellant's general practitioner #2] for the first time on June 17, 2009, his only reference was that the Appellant "had whiplash". In her second visit on August 31, 2009 the only note of complaints were with respect to her foot and she did not report neck and headaches in his chart notes until June 24, 2010 almost 18 months following the MVA.

[MPIC's medical consultant] concluded that the Appellant's cervical symptoms appear to have resolved with treatment and time. Counsel submitted that the same could be said for the Appellant's back pain.

<u>Credibility of Appellant</u>

Therefore, when the evidence of pain is not supported by objective evidence, it was submitted, the subjective reports of the Appellant must be analysed and must be found to be credible with respect to the reports and severity of pain.

The Appellant's testimony before the Commission was reviewed. During her direct examination, she was expressive, engaging and showed good recall of the facts. On cross-examination, she was combative and evasive and there were many times where her evidence and the evidence of the medical professionals who treated her were not consistent.

This occurred with regard to [Appellant's general practitioner #1]. The Appellant insisted he

examined her neck when there was no evidence that he did. The Appellant, reported to her case manager that she was not pleased with [Appellant's general practitioner #1] treating her injuries as minor, but in her testimony did not recall the incident and refused to concede the possibility that it had occurred. When the evidence did not support her, she did not acknowledge it as a fact.

Then, when meeting with [Appellant's general practitioner #2], the Appellant did not explain to him that she had sought him out for a second opinion due to her dissatisfaction with [Appellant's general practitioner #1]. He was left to assume that she was still being treated by [Appellant's general practitioner #1].

Counsel pointed to several examples in the Appellant's testimony where she did not recall documented exchanges between caregivers or case managers, including [Appellant's general practitioner #2] and [Appellant's physiotherapist #1], the physiotherapist.

Counsel submitted that the Appellant also self-limited in the work reconditioning program at [rehabilitation facility #2], failing to fully participate. Although the Functional Capacity Evaluation concluded that she likely had a greater level of function than displayed, it did find her reports of pain to be reliable. [MPIC's medical consultant] however, noted that her heart rate did not exceed 65 percent of maximum, suggesting a very low effort.

Discrepancies again arose when [Appellant's physiatrist #2] examined the Appellant's neck and found her symptoms to be soft tissue in nature. This led to the Appellant's complaint to [Appellant's general practitioner #2] that [Appellant's physiatrist #2] conducted no such examination, with [Appellant's general practitioner #2] then advising her to seek legal advice.

Counsel submitted that the evidence was also clear that the Appellant did not like the

physiotherapist [Appellant's physiotherapist #1], because she did not support the Appellant's approach to backing away from her return to work program. This led to her finding a new physiotherapist. That physiotherapist, [Appellant's physiotherapist #2], later indicated that while the Appellant's physical symptoms were improving, she now reported that her cognitive issues were more pronounced. After showing [Appellant's physiotherapist #2]'s report to [Appellant's general practitioner #2] in August 2011, [Appellant's general practitioner #2]'s chart notes indicated that the Appellant had instructed him not to provide a copy of that report to MPIC. However, the Appellant denied giving this instruction.

After her fall on May 31, 2011, the Appellant testified that [Appellant's general practitioner #2] diagnosed her with a concussion the following day. However, [Appellant's general practitioner #2]'s chart notes from that date do not support this and [Appellant's general practitioner #2] was not able to confirm that he diagnosed a concussion on that day. Nor did any devastating fall or concussion issues appear on the first, most important chronological listing of the issues discussed; rather what was listed first was the Appellant's dispute with MPIC.

Therefore, in respect of the Appellant's subjective reports of pain, MPIC submitted that the Appellant was simply not a credible witness. Where evidence did not support her position, she either could not recall facts or denied their existence altogether. During cross-examination she was combative, refusing to accept the possibility that [Appellant's general practitioner #1] would describe her injury as minor. She showed a propensity to select the opinions of medical professionals who supported her belief that she could not return to work and to discard those who challenged her. She instructed [Appellant's general practitioner #2] to hide information from MPIC and did not even inform him that he was a second opinion to [Appellant's general practitioner #1].

Where there is doubt regarding the credibility of the Appellant's reports of pain or the severity of them, counsel submitted that the Appellant's evidence must not be preferred to the available objective evidence.

When the Appellant did not return to her full-time employment, her failure to do so cannot be interpreted as inability to do so from a functional perspective. Her testimony that she desired to return to work was not credible, given her criticism of [Appellant's general practitioner #1]'s suggestion that she was ready to begin a return to work program and her continuously expressed concerns with her ability to successfully complete the return to work or work reconditioning programs.

In any event, the Appellant offered many different explanations as to why she could not return to work. At first, her focus was on the foot and ankle pain and weight bearing. When this appeared to be resolving, her concern shifted to cognitive issues and the potential for a fall. Finally, when she was placed at a desk job, she complained that the pain was now greater in her neck than in her feet.

In regards to her complaints of cognitive issues, counsel noted that the Appellant was not referred for any psychological assessment or intervention or counselling, beyond the assessment of [Appellant's psychologist] in 2015. [Appellant's psychologist] did not identify any evidence of significant cognitive impairment. It was submitted that his findings were consistent with how the Appellant presented herself at the hearing.

Therefore, MPIC submitted that the Appellant had not discharged her onus of proving on a balance of probabilities that the IRO erred in arriving at her decision. MPIC therefore submitted that the appeal must be dismissed.

[MPIC's medical consultant] testified that the Appellant's nursing job was not a hard job. It is difficult for the panel to accept this particular assertion.

Remedy

In the event that the Commission does overturn the IRD decision, MPIC submitted that the proper course of action would be to specify what signs or symptoms do relate to the MVA and refer that matter back to the case manager for implementation.

Discussion:

The Appellant was ably represented by [Appellant's representative], who, although not a professional advocate, presented the Appellant's case in an organized, thorough manner, making effective use of witnesses and visual aids to explain the medical evidence for the panel. Her presentation was delivered in a clear and concise fashion.

Counsel for MPIC also made submissions in a professional, respectful, collegial and concise manner.

Both of these contributions were appreciated by the panel.

The onus is on the Appellant to show, on a balance of probabilities, that she qualifies for entitlement to PIPP benefits as a result of a bodily injury caused by an automobile. The MPIC Act provides as follows:

> **Definitions**
>
> 70(1) In this Part,
>
> **"accident"** means any event in which bodily injury is caused by an automobile; (« accident »)
>
> **"bodily injury"** means any physical or mental injury, including permanent physical or mental impairment and death; (« dommage corporel »)
>
> **"bodily injury caused by an automobile"** means any bodily injury caused by an automobile, by the use of an automobile, or by a load, including bodily injury caused by a trailer used with an automobile, but not including bodily injury caused
>
> (a) by the autonomous act of an animal that is part of the load, or
>
> (b) because of an action performed by the victim in connection with the maintenance, repair, alteration or improvement of an automobile; (« dommage corporel causé par une automobile »)

Following a review of the evidence and submissions of the parties, including the opportunity to review medical reports, testimony and observe the demeanor of the Appellant, the panel finds that the Appellant has failed to meet the onus upon her of showing, on a balance of probabilities, that her current signs and symptoms were caused by the MVA.

The panel accepts the evidence that the Appellant suffered an initial injury in the MVA. While there may have been some difference of opinion among the experts as to whether the injury to her foot was an avulsion fracture, even [MPIC's medical consultant] ultimately concluded that he could see how that might have been a possible interpretation of the radiological scans. But even allowing for the possibility that there was an avulsion fracture, the evidence indicates that this

type of injury usually heals within 6 to 8 weeks. Even allowing for a slower recovery period, the Appellant's reported pain and disability, over a period of several years, is not consistent with the medical evidence regarding that type of injury.

Follow-up tests confirmed that there was healing and that any remaining possible issues with the Appellant's foot and ankle were degenerative in nature and could not be attributed to the MVA.

[Appellant's general practitioner #1] advised that the average recovery time for a small avulsion fracture was 6 to 8 weeks and later commented that according to his chart notes the Appellant expressed to him that her foot was better as of June 10, 2009. Further investigations showed signs of plantar and calcaneal spurs and noted possible osteoarthritis in her left foot which would have pre-existed the MVA. The panel agrees with counsel for MPIC that the available objective evidence supports his submission that the Appellant's left foot injury improved. Perhaps this occurred more slowly than normal, but it did improve over time to the point where her only remaining sign related to her subjective pain.

Then, the Appellant's condition seemed to evolve. Her reports of pain began to include cervical neck pain complaints, headaches, and finally, cognitive impairment. The evidence of her massage therapist and chiropractor described issues with neck range of motion and pain as well as cranial misalignment, which were rejected on a scientific basis in the evidence of [MPIC's chiropractic consultant], of MPIC's Health Case Services team.

It is also worth nothing that an MRI report of March 30, 2011 found no significant spinal abnormalities, beyond a possible congenital deformity.

The Appellant's complaints of cognitive impairment seemed to arise after a fall in May 2011, which was otherwise unwitnessed and undocumented but reported to her general practitioner the next day. [Appellant's general practitioner #2] suspected a fall might have been caused by side effects from her medications, while the Appellant asserted that it was due to the pain in her foot and balance problems resulting from the MVA. This panel finds that [Appellant's general practitioner #2]'s chart notes and testimony did not confirm the Appellant's evidence that he had diagnosed her on that day with a concussion. Rather, [Appellant's general practitioner #2] testified that his chart notes normally contain a chronological listing of the issues discussed and on that day the first issue discussed was not a devastating fall from the previous day, but rather the status of the Appellant's dispute with MPIC.

Although [Appellant's physiatrist #1] documented concern that the Appellant was slow in her mentation, opining that she may be depressed, he did not identify any requirement for psychological assessment or intervention.

The Appellant was of the view at one point that her cognitive issues had surpassed her improving physical signs and symptoms, yet [Appellant's psychologist] did not identify any evidence of significant cognitive impairment. He suggested the Appellant might be experiencing a moderate level of dysphoria or depression but he did not provide any specific prescription, only suggesting that she consider counselling. The cognitive symptoms reported by the Appellant were not supported by [Appellant's psychologist]'s findings.

Over six days of hearing, the panel took note of the Appellant's ability to sit and concentrate, taking thorough notes without demonstrating any pain behaviour. She actively directed and

assisted her counsel and quickly and accurately responded to questions from the panel. Her communications were clear.

This is therefore a case where there is a paucity of objective evidence to support a causal connection between the MVA and the Appellant's current condition. The panel has examined the subjective reports of the Appellant. The panel has also carefully reviewed and considered the list of inconsistencies in the Appellant's evidence which were presented by counsel for MPIC. Overall, the Appellant did not present a credible, reliable or consistent narrative.

During her direct testimony, the Appellant was expressive, engaging and had good recall of facts. On cross-examination, she was often combative and evasive and there were many times where her evidence and the evidence of the caregivers or the documented reports of caregivers and case managers were not consistent.

The Appellant claimed that [Appellant's general practitioner #1] examined her in relation to her neck, but there is no evidence he did. The documentary evidence indicates he treated her only for her foot injury. When asked whether she was annoyed with [Appellant's general practitioner #1] for indicating her injury was minor, the Appellant did not recall the incident and refused to concede the possibility that this may have occurred.

After reporting to [Appellant's general practitioner #1] on June 10, 2009 that her foot felt better, the Appellant met with [Appellant's general practitioner #2] a week later but did not bring to his attention this exchange with [Appellant's general practitioner #1]. She claimed that [Appellant's general practitioner #2] examined her on June 17, 2009, although [Appellant's general practitioner #2] did not agree with this and characterized that appointment as a "meet and greet", charting the need to fill out forms for benefits. The Appellant had not explained to [Appellant's

general practitioner #2] that she had sought him out as a second opinion and he testified that he assumed [Appellant's general practitioner #1] would continue to monitor the Appellant. The Appellant's complaints of foot pain increased after commencing her return to work program but [Appellant's general practitioner #2] diagnosed her with tendinitis and indicated that was part of the healing process. The Appellant did not recall this.

A Functional Capacity Evaluation (FCE) from January 19, 2010 concluded that the Appellant likely had a greater level of functioning than she displayed. Although this report found her reports of pain to be reliable and consistent with observations, [MPIC's medical consultant] noted that her heart rate did not exceed 65% of maximum, suggesting a very low effort. Despite a home exercise program, the Appellant's condition regressed, with her regaining range of motion but losing significant strength. There is some evidence that she self-limited during her reconditioning program at [rehabilitation facility #2] in April 15, 2010, complaining that she needed time to recover and could not fully participate in the program.

[Appellant's physiatrist #2] wrote that he examined the Appellant's neck and found her symptoms to be soft tissue in nature, but the Appellant argued that [Appellant's physiatrist #2] conducted no such examination, leading [Appellant's general practitioner #2] to advise her to seek legal counsel in that regard. [Rehabilitation facility #2] staff continued to report difficulties with the Appellant's participation in the reconditioning program and, although physiotherapy time was set aside there to address her pain complaints, she consistently refused such assistance.

The Appellant had expressed dissatisfaction with her former physiotherapist, [Appellant's physiotherapist #1], who continued to maintain that the Appellant should be at work. Then the

Appellant complained that the reconditioning back to work program was too much for her as she arranged an assessment with a different physiotherapist, [Appellant's physiotherapist #2]. Then the Appellant began to assert that her cognitive issues were more pronounced than the above noted physical symptoms.

MPIC submitted that the Appellant was simply not a credible witness regarding her subjective reports of pain. The panel agrees that when evidence did not support her position she either could not recall facts or denied their existence altogether. She instructed [Appellant's general practitioner #2] to hide information from MPIC and did not inform [Appellant's general practitioner #2] about the nature of her relationship with [Appellant's general practitioner #1]. She sought out caregivers who provided treatment of a gentle nature and avoided those who encouraged the return to work program.

In summary, the panel finds overall that the Appellant's evidence contained many inconsistencies. The panel took careful note of the differences in the Appellant's presentation during direct testimony and response to questions from the panel and the combative way she presented on cross-examination. She showed a propensity to select the opinions of medical professionals who supported her belief that she could not return to work and discard those who challenged her.

The panel's careful observation of the Appellant during her testimony and over the course of six days of hearings and the inconsistencies in her evidence led us to agree with MPIC's submission that where there is doubt regarding the credibility of the Appellant's reports of pain or severity of pain, her evidence should not be preferred to the available objective evidence.

Due to the absence of objective findings and the lack of reliable consistent evidence regarding the Appellant's reports of pain and efforts at rehabilitation, the panel finds that the Appellant has failed to show, on a balance of probabilities that her current symptoms and condition were caused by the MVA. Accordingly, her appeal from the IRD of November 15, 2012 is hereby dismissed, and the Internal Review Decision is upheld.

Dated at Winnipeg this 25th day of June, 2019.

LAURA DIAMOND

JANET FROHLICH

GUY JOUBERT