Manitoba

Automobile Injury Compensation Appeal Commission

IN THE MATTER OF an Appeal by [the Appellant]
AICAC File No.: AC-12-030

PANEL:	**Jacqueline Freedman, Chair** **Brian Hunt** **Sharon Macdonald**
APPEARANCES:	**[Text deleted] (the "Appellant") was represented by [Text deleted];** **Manitoba Public Insurance Corporation ("MPIC") was represented by Matthew Maslanka.**
HEARING DATES:	**May 4, 5, 6, 12 and 13, 2021**
ISSUE:	**Whether the Appellant's medical condition is causally connected to the motor vehicle accident.**
RELEVANT SECTION:	**Subsection 70(1) of The Manitoba Public Insurance Corporation Act (the "MPIC Act").**

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

Reasons For Decision

Background:

The Appellant was the driver of a vehicle on September 16, 2006, when she was stopped at a red light and was rear ended (the "MVA"). The Appellant suffered injuries as a result of the MVA and received treatments pursuant to the Personal Injury Protection Plan ("PIPP") provisions of the MPIC Act, including physiotherapy treatment.

The Appellant's physiotherapy treatment concluded in December, 2006. She contacted her case manager in July, 2007, to seek funding for chiropractic treatment, but funding was denied. Subsequently, the Appellant contacted MPIC in July, 2008, and advised that, as of February 2008, due to the injuries sustained in the MVA, she was unable to continue her employment as a [text deleted]. She requested Income Replacement Indemnity ("IRI") benefits. The case manager considered the request of the Appellant, and the medical information was reviewed by MPIC's Health Care Services ("HCS") consultants. The case manager issued a decision dated December 10, 2008, which states, in part, as follows:

> The information does not support that your current symptoms are causally related to the incident of September 16, 2006. Therefore, there is no entitlement to IRI benefits under the Personal Injury Protection Plan as a result of the September 16, 2006 motor vehicle accident.

The Appellant provided further medical information to MPIC. After further review and consultation with the HCS consultants, the case manager issued a further decision, dated February 10, 2010, confirming the earlier decision.

The Appellant disagreed with the decisions of the case manager and filed Applications for Review. The Internal Review Officer considered the decisions of the case manager, as well as additional medical information received to the file, and upheld the decisions of the case manager. The Internal Review decision, dated December 6, 2011, provides, in part, as follows:

> Having considered all the information on your file, the case manager decisions of December 10, 2008 and February 10, 2010, respectively, are confirmed in that the medical conditions you complained of between the period February 21, 2008 and September 2, 2008 are not causally related to the incident and that it was your decision to refrain from working to accommodate your symptoms rather than being secondary to any physical impairment related to the accident. […]

The Appellant disagreed with the decision of the Internal Review Officer and filed this appeal with the Commission.

A Case Conference was held in this matter on June 28, 2019, to discuss pre-hearing matters. Given that the case manager and the Internal Review Officer had considered the issue of causation, the parties agreed to redefine the issue under appeal from one of IRI to one of causation. This was confirmed with the parties at the outset of the hearing.

Issue:

The issue which requires determination on this appeal is whether the Appellant's medical condition is causally connected to the MVA.

Decision:

Following a review of the documentary evidence on file, the testimony of the witnesses and the submissions of the parties, and for the reasons set out below, the panel finds that the Appellant has not established, on a balance of probabilities, that her medical condition is causally connected to the MVA.

Preliminary and Procedural Matters:

This hearing was held during the COVID-19 pandemic, and took place entirely by videoconference, with the consent of the parties.

As noted above, at the outset of the hearing, the panel confirmed with the parties that the issue under appeal had been agreed to by them as stated above. The parties also confirmed that they had further agreed at the Case Conference that if the Appellant were to be successful in her appeal, the matter would be referred back to MPIC for a determination of the PIPP benefits to which she may be entitled as a result of the Commission's decision.

Also at the outset of the hearing, the panel dealt with new evidence recently submitted by each party. The panel identified the evidence, and the other party did not object to its admission. Accordingly, the MPIC file note dated December 19, 2006, submitted for inclusion to the indexed file by MPIC was added as Tab 153. The copy of a December 15, 2016, upright cervical spine MRI, contained on a disc, submitted by the Appellant was marked as Exhibit 1.

Finally, in advance of the hearing, the Commission had noted that a caregiver of the Appellant who would be testifying, [sports medicine physician], works in the same medical clinic as [MPIC's HCS medical consultant], who would be testifying for MPIC. The Commission had raised this issue with MPIC, who advised that they did not have any issues, legal or otherwise, with [MPIC's HCS medical consultant] presenting evidence at this hearing. The Commission provided this information to counsel for the Appellant in advance of the hearing. At the hearing, he advised that there were no issues in this regard from the Appellant's perspective.

Opening Statements:

After concluding discussions of the preliminary matters, the parties were then invited to give opening statements. Counsel for each party briefly stated their respective positions, which will not be summarized here, as their positions were reflected in their submissions, below.

Legislation:

The relevant provisions of the MPIC Act are as follows:

> **Definitions**
> 70(1) In this Part,
> **"accident"** means any event in which bodily injury is caused by an automobile;

> **"bodily injury"** means any physical or mental injury, including permanent physical or mental impairment and death;
>
> **"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 [...];

Evidence for the Appellant:

The Appellant provided numerous medical reports from health care providers in support of her appeal. She also testified at the hearing, along with her treating chiropractor [text deleted], her consulting chiropractor [text deleted], and her sports medicine physician [text deleted].

The Appellant:

The Appellant testified and was cross-examined at the hearing of her appeal.

The Appellant described her life prior to the MVA. She worked as a [text deleted], and had been in that position for several years. Her duties included providing assistance with classroom activities, such as reading and writing, as well as assisting with dressing and washroom activities, providing outdoor supervision, and monitoring behaviour. She also described a full social life, including travelling and outings with friends, as well as an active recreational life, participating in numerous sporting activities. The Appellant said that she had no health issues prior to the MVA, and in particular nothing that prevented her from working or participating in her social and recreational activities.

The MVA occurred while the Appellant had been at a complete stop at a red light. She was hit from behind and pushed into the intersection approximately 5 to 6 feet; there was no one in front of her. She said that immediately after the MVA, even the day after, she felt fine. However, two days later, her back and neck were “on fire”. She was extremely stiff, with pain from the top of her head to the

bottom of her back. She also felt nauseous. She went to see her physician, [text deleted], who referred her to [physiotherapy clinic]. Prior to the MVA, she had never experienced pain in these areas. She acknowledged that she had been nauseous when she had had a flu from time to time, but not on any other occasion. The nausea she felt after the MVA was similar, but it never went away. She later became subject to bouts of vomiting, which became worse and more frequent. Prior to the MVA, she had never experienced bouts of vomiting.

The Appellant described how the MVA impacted her ability to work. She said that she needed some time off work. When she returned to work, first part-time, then into full time, she was going to physiotherapy three times a week. She still had head and back pain, and she was doing treatments after work solely in order to be able to work the next day. She had pain with standing, bending, sitting and other movement at work. Leaning over young children was very painful; at the same time, having to go on her knees to get to their level was also very difficult. She had to bring in pillows to the classroom for back support. The teacher in her classroom saw a decrease in her energy level, due to the pain that she was experiencing. All of her energy went into performing at work, so her ability to function outside of work went down.

She was discharged from physiotherapy on December 5, 2006, and was provided home exercises, which she did. Her physiotherapist noted on the discharge report that her condition was much improved on discharge, and the Appellant agreed with that. She said that her back started to improve, and there was more agility. She had some lingering minor back pain and neck pain, she was subject to bouts of vomiting, and she was starting to have some dizziness. Although she had some remaining symptoms, the Appellant did not stay away from work, because she thought that she would get better and that it would just take time. However, she was not symptom-free at work, and many times she

would have to leave the classroom in order to vomit. Further, she had not returned to playing recreational sports at that time, because she was in too much pain.

The Appellant said that although she had hoped she would continue to improve after her discharge from physiotherapy, in fact she worsened, with increasing back and neck pain, nausea and vomiting, and muscle spasms. She called MPIC in January or February, 2007, and requested more physiotherapy treatment, but was denied. In February, 2007, she began to go for acupuncture treatment, which she had until December, 2007, and which provided temporary relief. She also began to go for massage therapy with various providers (although she did not document the treatments prior to August, 2007). She needed the acupuncture and massage treatments in order to be able to work all day, because she was still working full time and it was extremely difficult. She still needed to bring a pillow to work, and was still vomiting regularly. She had not resumed her recreational or social life at that point. She went to see her physician, [Appellant's physician] in February, 2007, and told her that she had back and neck pain, and also nausea and vomiting. [Appellant's physician] thought that the nausea and vomiting were related to something other than the MVA and that was what she investigated. The Appellant initially thought that it was caused by food poisoning, although she later related it to the MVA.

From February to May, 2007, the Appellant's nausea and vomiting were getting progressively worse, and she went to see [Appellant's physician] often. She also made several visits to hospital emergency rooms due to these complaints. She had difficulty keeping food down, and also suffered from diarrhea. She said she also suffered from back and neck pain at this time, but during this period, the nausea and vomiting were worse, and they overtook the other pain and became her focus for a few months. She estimated that in May, 2007, she was vomiting 3 to 4 times a week. She was still working full time, but she took a lot of sick days and rested a lot. In addition, the massage and acupuncture

treatments were also addressing her abdominal pain and did help a little bit. However, she had difficulty taking in nutrients and she lost 30 pounds.

When asked about a June, 2007, vacuuming incident described in a HCS report, the Appellant said she recalled that her daily cleaning chores were becoming more difficult, due to the fact that her back was sore. The vacuuming did not start a new symptom; her back had already been sore and the vacuuming aggravated her back. This was the same symptom she had been having since the MVA. Similarly, when she went to see a new chiropractor in July 2007, she had the same symptoms at that time as she had prior to the vacuuming incident, and these were the symptoms that she had been continuously struggling with since the MVA. They had improved a little bit from physiotherapy, but they had never subsided, and then they got worse. She had not returned to her recreational activities at that point, and in fact she was having difficulty even sleeping at that time.

The Appellant continued to seek treatment from her doctor and many specialists. She noted that when she went to see [sports medicine physician] in April, 2008, her neck and back pain were worse than her nausea and vomiting. She had ceased working in February, 2008. She later returned to work, on a part-time basis, from September, 2008, until September, 2012. She has not returned to work since September, 2012. She said the constant neck and back pain, nausea, vomiting and diarrhea overtook her life, and she was only able to function on a limited basis, doing things for a few hours, and then having to rest for a few hours. She also has insomnia. She eventually sought treatment in [text deleted], and was diagnosed as having craniocervical instability ("CCI") and cerebellar tonsillar ectopia ("CTE"). She is now going to the [text deleted] to receive stem cell treatment and chiropractic treatment for these conditions, as that treatment is not available in Manitoba. She has seen some improvement, in that she is able to eat now, and understands that it is necessary to keep her neck in

a certain position, but she is not sure if she will ever recover. She has never recovered her pre-MVA level of activity.

The cross-examination of the Appellant briefly covered the details of the MVA and the injuries she reported in her Application for Compensation, completed on October 17, 2006. Cross-examination also covered the amount of time that the Appellant initially was away from work. She confirmed that the MPIC file note dated October 19, 2006, was accurate in stating that she had taken off four days in September, 2006. Then, on October 5, 2006, she started working part-time hours, and returned to work full time on October 19, 2006.

The Appellant was asked about her physiotherapy treatment following the MVA. She acknowledged that the treatment helped her, and agreed with [Appellant's physician]'s chart notes in October and November, 2006, that she was getting better, and was much improved at that time. When questioned as to why she did not return 4 to 6 weeks later for follow-up after the November, 2006, appointment, as requested by [Appellant's physician], the Appellant said that it was not because she was feeling better; rather, she was just trying to manage with the medication she had been given, and she thought that her condition would mend on its own. She acknowledged that her physiotherapist's clinical notes indicate improvement over this time period. The Appellant did partake in some social activities, like attending at two weddings, but was very stiff afterwards, and felt sick the next day. On November 30, 2006, the physiotherapist noted that the Appellant was having no difficulty at work, and that her attendance was irregular. The Appellant did not recall why she would not have been attending, although she thought she could have been too sick to attend. She did acknowledge that there could have been some good days; she was doing better because of the physiotherapy. She was questioned regarding her statement that she asked MPIC for further physiotherapy in January or February, 2007,

and she acknowledged that the absence of documentation of her request could suggest that she was mistaken as to the timing.

The cross-examination also covered the Appellant's difficulties with nausea and vomiting. She noted that the nausea began immediately following the MVA, while the onset of vomiting occurred in November, 2006. Initially, it occurred monthly, then progressed to weekly, and continued progressing such that she felt she should seek medical care. She did not initially attribute it to the MVA, although she later did, and she feels her doctor should have. She was referred to various specialists, including, in late 2007, [text deleted], a gastroenterologist, who diagnosed her with IBS (irritable bowel syndrome). She continues to see [text deleted], also a gastroenterologist, who has been treating her since 2013 for that condition and prescribing medication. When questioned, the Appellant said that [gastroenterologist #2] has never indicated that he thinks her IBS was caused by the MVA.

The Appellant was questioned in detail regarding the extent of her difficulties in May and June of 2007. She said that at that time, she would be vomiting 3 to 4 days one week, then perhaps a week off, then 2 to 3 days the following week, and on a day when she was vomiting, it would be for five hours at a time. She could be crouched in front of the toilet, and would need to keep a bucket by her bed. The vomiting was forceful and uncontrollable. When asked whether being in the constant state of being prone over the toilet would cause back pain, the Appellant said that her back pain was already present. She acknowledged that she was seeing an increase in her back pain during this time; however, all of her problems were increasing, including her back, neck and hip pain, and she kept seeing specialists but was not getting answers.

The vacuuming incident on June 24, 2007, was another area of cross-examination. The Appellant said that she had had pain since the MVA. Although she had been feeling a little better from

physiotherapy, it was getting worse, and daily activities were becoming difficult. The vacuuming made it increase further, because she exerted herself in a way that she shouldn't have, and the pain intensified. However, she did not consider the vacuuming incident to be an important event. By the summer of 2007, the Appellant had started to relate all of her physical ailments to the MVA. She said that the MVA was the most significant event and it was the only thing that had changed in her life. Although she had mentioned the vacuuming incident to the case manager and described it in her notes, the Appellant said the reason she didn't mention it to her health care providers was because she had probably forgotten it, due to all her other symptoms overwhelming her. She disagreed with the suggestion that she downplayed the incident due to MPIC's reliance on it in denying her further chiropractic treatment. Rather, she insisted that she was of the view that a vacuuming incident could not be significant, and that it would not disrupt a person's life to this extent, and in fact anything she would do caused her pain.

The Appellant confirmed that the letter from her co-worker dated June 12, 2013, was generated at the request of her former counsel, as was the letter from her acupuncturist dated July 25, 2013. She said that in 2007, when she was getting the acupuncture treatment, she was told by MPIC that reimbursement for such treatment was unavailable. The Appellant said that she was getting acupuncture treatment for her gastric issues, and as well for her neck and back pain.

[Appellant's treating chiropractor]:

[Text deleted] is the Appellant's treating chiropractor. He saw her initially from August, 2007, to February, 2008, and then she returned to his care in September, 2018. In addition to his testimony at the appeal hearing, he provided reports dated June 13, 2013, and October 23, 2020, as well as copies of his clinical notes.

He has been a chiropractor for over 25 years, and described his practice as a standard, traditional practice, where he has treated everything from musculoskeletal injuries to everyday pains, whether arising from motor vehicle incidents, slip and falls or otherwise.

He first evaluated the Appellant on August 31, 2007. He noted that at that time, she presented with mid back and low back pains, and upset stomach, and she identified that those symptoms began following the MVA and worsened in May 2007. [Appellant's treating chiropractor] diagnosed the Appellant with mid thoracic spinal dysfunction, rib dysfunction and sacroiliac joint dysfunction. He said that this diagnosis did not account for her symptom of stomach upset; this was a symptom that he could not account for, and he just noted it. He provided 43 treatments to February, 2008. During that time, she was also going for physiotherapy, acupuncture and imaging. His care was limited and provided short-term relief but nothing long-term. He would not say that he was able to successfully treat her during that period of time.

The Appellant returned to his care in September, 2018, in the context of her ongoing appeal of MPIC's decision. She brought him the digital motion x-ray ("DMX") and upright MRI that had been done in [text deleted]. in 2016. He reviewed that imaging, taking into account the fact that the Appellant was subject to a rear-end collision, and arrived at the diagnosis of CCI, craniocervical instability. He explained that "cranial" refers to the skull and "cervical" refers to the neck. The area where these two meet, between the first and second cervical vertebrae, has just ligaments, and no disc; these ligaments can be stretched or weakened by trauma such as whiplash. The ligamentous laxity would explain all of the symptoms that the Appellant presented with when [Appellant's treating chiropractor] saw her in 2018, including chronic pain in her head and neck, headaches, dizziness, nausea, visual disturbances, digestive disturbances, muscular problems and gastric issues.

[Appellant's treating chiropractor] concluded that the Appellant's symptoms were caused by the MVA, and that remains his opinion. This type of instability is most commonly associated with trauma or whiplash. Although it does have other causes, such as rheumatoid arthritis, Downs Syndrome or Ehlers Danlos Syndrome, none of these are applicable to the Appellant. This is not the type of injury you would expect to see from someone who hurt themselves vacuuming, because there is not enough trauma. CCI was not his initial diagnosis; he conceded that his initial diagnosis was incorrect, but it was based on the information that he had at the time. The symptoms that the Appellant presented with at that earlier time, including back pain, jaw pain and stomach ache, are consistent with her current diagnosis of CCI, he just didn't have the correct diagnosis and didn't know where to place them. The fact that she had physiotherapy and improved as a result does not change his opinion. CCI usually progresses over time, and the body needs to compensate; it is possible that the physiotherapy did allow her to improve, but afterwards her body couldn't hold the improvement, and then she deteriorated.

[Appellant's treating chiropractor] explained that the reason that the imaging that the Appellant had done in Manitoba did not show the same results as the [text deleted]. imaging is because these type of images are not done in Canada; although they may be approved, there are not DMX facilities here. Since the Appellant returned to his care 2018, his treatment role has been supportive. She has been going to the [text deleted] for stem cell treatments to stabilize the ligaments in her upper neck. This kind of treatment is not done in Canada. She also sees a chiropractor in the [text deleted] to support that treatment. He does treatment to support her lower body compensation, in her mid thoracic, lower lumbar, and sacroiliac areas, in between her visits to the [text deleted]. Since the pandemic she has not been able to go to the [text deleted] for treatment. His treatments keep her functioning for only a day or two afterward.

On cross-examination, [Appellant's treating chiropractor] agreed that there could be various causes of neck and back pain. Such pain could develop through normal daily activity, including household chores such as vacuuming, although he noted that when patients came to him with back pain arising from vacuuming, they responded to treatment, and the pain was not prolonged. [Appellant's treating chiropractor] agreed that the duties of the Appellant's job could produce neck and back pain, as could being hunched over a toilet for several hours in order to vomit. He also agreed that an upset stomach is not a common sequelae to an MVA that causes soft tissue injuries.

[Appellant's treating chiropractor] was asked about his early treatment of the Appellant, between August, 2007, and February, 2008, and whether he became aware of any neck issues during that time. He said that he was treating her at that time for her mid and low back issues. Therefore, his statement in his October 23, 2020, report that she is "in constant chronic pain in her head and neck region" is not a reference to her state as of the date of the MVA. Similarly, his physical findings listed in that report were not the same as those noted in 2008. On redirect, [Appellant's treating chiropractor] clarified that on his initial examination of her in August, 2007, he noted a mild lordosis at C5-6, but he was not actively treating her for that. He was not aware as to whether she was getting treatment for it elsewhere.

Cross-examination covered the nature of the Appellant's symptoms, and degrees of trauma. When asked if the absence of cervical symptoms up to February, 2008, suggests that the Appellant did not have CCI at that time, [Appellant's treating chiropractor] said that the literature suggests that it is not uncommon that CCI develops over time, as the body compensates after trauma. Even though she did not display pain in her head and neck, the Appellant was vomiting and having pain elsewhere, such as in her mid back. He said that there are different degrees of trauma, such that ligament damage would not likely be caused by vacuuming, whereas it would likely be caused by a car accident. When

pressed regarding the degree of trauma involved in this MVA, where the Appellant was able to get out of the vehicle, drive home, and did not seek medical attention for two days, [Appellant's treating chiropractor] said that the literature indicates that most people feel the effects later, as the forces transmit through the body, and the ligaments are not torn, but just stretched. He acknowledged that the Appellant is his first patient with CCI. She brought him the literature that he referred to. He has never previously interpreted a DMX x-ray.

[Appellant's treating chiropractor] was asked about the infrequency of this diagnosis, given the relatively minor nature of the MVA. He said that it depends on the position of the neck, which direction someone is looking and the load on the ligaments. Here, the Appellant was unfortunately in the wrong position at the wrong time. He has educated himself on this condition, and ligamentous laxity causes irritation of the brain stem, and although these findings were not made until ten years after the MVA in the Appellant's case, that length of time is not unusual, and people develop more symptoms as time goes by with this condition. He is not certain whether her condition will eventually be resolved, or to what degree she will be stabilized, although her gains through the treatment that she is undergoing in the [text deleted] are better than through other treatment that she has undergone previously. Now, she can go several months between treatments with her [text deleted] providers, and her dizziness and nausea have decreased in severity and intensity.

[Appellant's consulting chiropractor]:

[Appellant's consulting chiropractor] is a chiropractor who practices in [province]. He consulted with the Appellant to provide a second opinion in July, 2017 (he did subsequently meet with the Appellant in February, 2018). In addition to his testimony at the appeal hearing, he provided a report dated July 6, 2017.

He has been a chiropractor for over 30 years. He started off his practice in diversified technique, and then got into diagnostic services. He has been involved with over 6,000 personal injury patients and has been published in peer-reviewed publications. In 2005, he acquired DMX equipment. He noted that DMX is a trade name, for which he has the "intellectual copyright" in Canada. He described the difference between regular x-rays and DMX technology, video fluoroscopy, as being the difference between a still camera and a video camera; a DMX shows the movement of vertebrae, and can show things that are not picked up on regular x-rays.

[Appellant's consulting chiropractor] is familiar with CCI, and said that his practice deals almost exclusively with patients who have craniocervical syndrome ("CCS"). CCI is a more severe form of CCS. With CCS/CCI, the issue is misalignment at the craniocervical junction, the area where the head connects to the neck. If the spine gets twisted, the cerebellar tonsils may get into the foramen magnum (which is known as CTE), and block the flow of cerebral spinal fluid, impairing blood flow to the brain, which can cause a traumatic brain injury. This can result in numerous symptoms, including headaches, neck pain, dizziness, and problems with balance, memory, and concentration. A person with CCI would be physically unstable. Where an injury to the neck affects blood flow to the brain, it would be easily aggravated, and the person would be quite symptomatic.

The Appellant provided several reports from [text deleted] to [Appellant's consulting chiropractor] for his review:

- a DMX imaging report dated December 15, 2016, from [text deleted], chiropractor;
- an upright MRI dated December 15, 2016, from [radiology clinic]; and
- a report dated December 16, 2016, from [text deleted], neurosurgeon.

[Appellant's consulting chiropractor] provided his opinion in a report dated July 6, 2017. He said that he reviewed the DMX imaging, and was able to repeat the measurements done by [chiropractor]; he therefore agreed with his assessments. In his testimony, [Appellant's consulting chiropractor] reviewed the most significant DMX findings, as outlined in his report, explaining in detail the ligament and facet damage identified on the DMX imaging. He noted in particular the damage to the Appellant's alar ligaments bilaterally, which he pointed to as evidence that there was trauma that happened to both ligaments simultaneously, because these ligaments would not both spontaneously rupture. A rear-end collision would account for this kind of damage, if the force were severe enough; in his view, it had to have been a "very violent impact". Vacuuming could not account for this kind of damage, although it could aggravate the condition. The upright MRI demonstrated that the Appellant suffered from CTE, and this obstructs the flow of spinal fluid. This MRI did not do proton sequences, which would have been preferable, but it does confirm the damage to the alar ligaments. The consequence of the ligament damage is that mechanical stress is being put on the Appellant's brain, and creating all kinds of symptoms. [Appellant's consulting chiropractor] said he agreed with the diagnosis made by [neurosurgeon], which was that the Appellant had sustained severe neurologic and spinal damage, resulting in instability at C1-C2. He also agreed with [neurosurgeon] that the MVA was the cause of this damage, because having reviewed the documentary evidence provided to him in preparation for the appeal hearing, he saw no indication that there was any other trauma that could account for this damage.

[Appellant's consulting chiropractor] said he would expect the Appellant to be suffering from numerous symptoms, including headaches and neck pain, ringing in the ears, and problems with balance, memory and concentration. Mid and low back pain could also manifest, as could nausea and vomiting. It is not uncommon for people with this condition to have their muscles reach exhaustion and end up with chronic pain. In addition, if they feel dizzy they may get nauseous. Although the

Appellant had an initial improvement after physiotherapy treatment, that is not unusual. In his view, the Appellant suffered a structural injury, and then slowly, over the course of weeks and months, the activities of daily living took their toll. In the early window post-injury, she was able to show some physical improvement from the muscle pain, but the neurological pain then arose and persisted, because the derangement came up over time.

On cross-examination, [Appellant's consulting chiropractor] was questioned regarding the DMX, or video fluoroscopy, technology. He said that it is used in hospitals, just not for this protocol. In Canada, at one time there were three machines used for this protocol, but now he is the only person who does it. When asked why it was not more common, if it was so useful, he said that one reason is cost, and another reason could be that perhaps other chiropractors are not interested in doing x-rays in their office. [Appellant's consulting chiropractor] said that he has dealt with several hundred patients having CCI.

Cross-examination also covered [Appellant's consulting chiropractor]'s testimony regarding his opinion on causation. In response to the question as to what would constitute a "very violent impact", he said that he was referring to the forces going through the person, as opposed to vehicular damage, as those could be different. He said that in his experience, it's not always the case that one would see signs of injury immediately following the impact. Although he was not able to say how often this occurred, he said that he has seen cases develop into CCI from MVAs that had no effect for a few days. He acknowledged that a person's general presentation following the MVA is relevant to a causal analysis. [Appellant's consulting chiropractor] was of the view that the Appellant's back pain was secondary to a neck injury that put pressure on her spine. The physiotherapy could have improved the back pain, but not the neck pain. At the time of the physical injury in the MVA, she would have had pain in the muscles, and that would have slowly healed, but it wouldn't change the fact that the

ligament disruption would slowly cause damage to the nervous system. When questioned about the fact that [Appellant's treating chiropractor] did not note any cervical problems from August, 2007, to February, 2008, [Appellant's consulting chiropractor] said that "some of these observations are confounding". However, he reiterated his view that unless there was another significant trauma, the most plausible explanation is the MVA. He said that he has heard of people where the problem didn't emerge until several years later, and there is no hard and fast rule; not everybody will complain from day one. He did not have an answer as to the longest time from the event causing the injury to the problem becoming evident.

[Appellant's consulting chiropractor] was questioned regarding the diagnosis of CTE. He acknowledged the comments of [text deleted], a radiologist in [text deleted] who had also reviewed the upright MRI at the Appellant's request, and who said he was "not impressed by the degree" of CTE. [Appellant's consulting chiropractor] was of the view that [radiologist]'s comments do not impugn his analysis. He agreed that there is no flow study which shows the disruption to spinal fluid. In his experience, cerebellar tonsils at the Appellant's level can affect the cerebral spinal fluid. He has sent approximately thirty of his own patients having similar malformations for a flow study, and they all had a flow blockage. He has also authored two chapters in publications on this issue. [Appellant's consulting chiropractor] acknowledged that the upright MRI did have some deficiencies. However, he was of the view that these deficiencies would only affect the extent of the findings, but did not undermine his conclusions. He did agree that depending on the individual reviewing the findings, there could be a difference in conclusion from one specialist to the next. When asked whether somebody else could look at the Appellant's DMX and come to the conclusion that there was no instability, he said that he didn't think any neurologist would say that it was normal. Thresholds are used to determine the range of movement, and if the movement is above the threshold, that is considered to be a permanent impairment by the A.M.A. (American Medical Association). It

is not likely that a future DMX would lead to the conclusion that the Appellant did not have CCI, unless she had stem cell therapy. In any event, it is not the practice for a patient to have multiple DMX imaging, due to the radiation involved.

[Sports medicine physician]:

[Text deleted] has been the Appellant's treating sports medicine physician since April, 2008. In addition to his testimony at the appeal hearing, he provided reports dated May 27, 2008, February 17, 2014 and February 26, 2015, as well as copies of the first year of his clinical notes.

[Text deleted] has been a sports medicine physician for over 20 years, doing mostly clinical work. He has done some teaching at [university], and in the past has done some consulting with MPIC and with the Worker's Compensation Board.

He first saw the Appellant on April 14, 2008. She advised him that she had back pain and cervical pain since the MVA, as well as abdominal pain and emesis (vomiting), although her major complaint at that time was back pain. He assessed her with chronic mechanical low back and thoracic pain, which most often is caused by trauma. As [sports medicine physician] continued to see the Appellant through late 2008 and into early 2009, his assessment was that she had a chronic pain presentation.

[Sports medicine physician] discussed his February 17, 2014, report. He noted that he had been seeing the Appellant since 2008, and continues to see her to date, every month or two. Since he has been seeing her, as noted in his report, she has had relatively consistent complaints of neck and low back pain, with frequent bouts of nausea and decreased appetite, in conjunction with fatigue and sleep disturbance. Those symptoms remain to date, although less so in her low back. The intensity has varied, and her symptoms have affected her tolerance for recreational activities and her ability to work. Her symptoms would be classified as a somatic or functional based diagnosis. With such a

diagnosis, there are often minimal objective findings, or finding such as fatigue, nausea, and headaches that are hard to image. It is his view that the symptoms were caused by the MVA. That remains his opinion today. He does not agree with the diagnosis of CCI.

In preparing his report, [sports medicine physician] did an extensive review of the documents, and these formed the basis of his opinion. He noted that when the Appellant was discharged from physiotherapy, she was improved, but her condition was not resolved, and she had some lingering symptoms. Although the words "much improved" on the physiotherapy discharge report are powerful, the issue is whether you have tested her abilities to return to work, recreational and other activities with full function, and he didn't get the sense that the Appellant was able to do that. [Sports medicine physician] also relied on the report of [specialist], whom the Appellant had seen in late November, 2008, and who was also of the view that the MVA was the cause of the Appellant's problems. He also referenced [Appellant's physician]'s June 5, 2009, report. He noted that in February, 2007, when the Appellant's nausea and abdominal complaints were being investigated, although it did not appear that there was anything organic going on, this is likely because there was still ongoing pain related to the MVA. The July 25, 2013, report from the Appellant's acupuncturist showed continuation of symptoms and documentation that she was still seeking treatment. In [sports medicine physician]'s view, the vacuuming incident may have aggravated her condition, but it was not the material cause, as her symptoms had continued throughout. He remains of the view that the Appellant's symptoms were caused by the MVA. He is aware that [MPIC's HCS medical consultant] has a different opinion. They do have a similar practice. As to why they would have different opinions, [sports medicine physician] said that he has the benefit of seeing the patient, and therefore he approaches the analysis from a different perspective.

On cross-examination, [sports medicine physician] agreed that there could be various causes of neck and back pain. Such pain could develop through normal daily activity, including household chores such as vacuuming, and someone could even be unaware of what brought on the pain. [Sports medicine physician] agreed that the duties of the Appellant's job could produce neck and back pain, as could being hunched over a toilet for several hours in order to vomit, if it was for a prolonged period of time.

Cross-examination also reviewed the mechanism of the MVA. [Sports medicine physician] said he would probably rate it as a minor collision. When asked how he would explain the Appellant's soft tissue injuries improving, but then later deteriorating, he said that sometimes a patient might have an incomplete recovery, or might undertake new activities that challenge their tolerance. He said that it is hard to define a timeframe of how much later in time it would stop being plausible that the minor injury is the cause of the re-emergence of symptoms. The better test is whether the patient is back to their full activities; each case should be viewed on its own merits. On redirect, [sports medicine physician] said that the June 12, 2013, letter from the Appellant's co-worker showed that the Appellant was not working at full capacity, but rather with symptoms. He said that the Appellant's evidence that she did not return to her social and recreational activities is further evidence that there was a continuation of symptoms, and is inconsistent with full recovery. Also on redirect, when asked why the Appellant did not recover within the expected six week timeframe that typically occurs with a soft tissue injury, [sports medicine physician] said that some cases are not part of the bell curve.

On cross-examination, [sports medicine physician] acknowledged that in February, 2007, when the Appellant presented with abdominal symptoms, and said she had been vomiting for the previous two months, he may not have related her symptoms to the MVA, and it is more in retrospect that he did so, given her higher levels of pain and dysfunction. In his view, it is more likely than not that her

somatic symptoms were caused by the MVA, including her fatigue and her nausea. Even if food poisoning were the initial assessment, this would not have been correct, because it would not have continued. [Sports medicine physician] agreed that a gastrointestinal specialist has diagnosed the Appellant with IBS, and that she still receives treatment for that. As to whether the IBS was caused by the MVA, he said that the IBS could be part of the Appellant's somatic symptom disorder, as IBS is a diagnosis of exclusion.

[Sports medicine physician] was questioned regarding his February 17, 2014, report. He agreed that his conclusion on causation was based on the Appellant having no pre-existing problems, and the continuation of her symptoms from the MVA to date. He acknowledged that if there had been recovery and return to activity, that would change his opinion. [Sports medicine physician] relied on the report of [specialist], and agreed that if there were inaccuracies in [specialist]'s report, that would have the potential to change his opinion. He did not agree that [specialist]'s comment that the Appellant had physiotherapy for four months, as opposed to two months, was significant; nor did he consider that his statement that the Appellant felt pain the day after the MVA, rather than two days after the MVA, was significant. [Sports medicine physician] was questioned regarding the continuity of the Appellant's symptoms following her discharge from physiotherapy in December, 2006. He noted that she went for acupuncture treatment, and even if there had been no evidence of that, he said his opinion would not change, because she still had symptoms, and was trying to cope. She was seeing her doctor for nausea, and if she was not mentioning her other pain, perhaps the nausea was the biggest concern at the time. [Sports medicine physician] was of the view that the vacuuming incident was not significant, because the Appellant had not had full resolution of her symptoms after physiotherapy. He said the changes in the Appellant's complaints over time do not affect his opinion.

[Sports medicine physician] did not agree with the diagnosis of CCI. He said he did not think that most radiologists would give that diagnosis. He did not think an upright MRI was very common. When asked whether CCI was a "eureka" diagnosis that could finally explain everything for the Appellant, [sports medicine physician] said that while it's possible that this could be a burgeoning field, this is unlikely, and it seemed to him to be more of a "fad". Sometimes in medicine he sees this, and these "fizzle out over time".

He was asked his views regarding the HCS report of [MPIC's HCS medical consultant] dated January 24, 2018. He said that he agreed with the analysis offered by [MPIC's HCS medical consultant] on the first page of his report, and did not disagree that he came to a reasonable conclusion based on that analysis. [Sports medicine physician] was also asked his views regarding the HCS report of [specialist #2], dated October 8, 2013. He said that given that this report was written before the letter was received from the Appellant's acupuncturist, the conclusion reached by [specialist #2] was not unreasonable, based on the information that MPIC had at the time. However, [specialist #2]'s analysis that the Appellant's low back pain was not a major issue prior to June, 2007, did not suggest to him that it was caused by the vacuuming incident; in his view, while vacuuming could be a cause of back pain, it can also be additive, and the Appellant was not always consistent in reporting her symptoms.

Evidence for MPIC:

In addition to numerous HCS medical reports and case managers' notes on the Appellant's file, MPIC called as a witness one of its HCS consultants, [text deleted].

[MPIC's HCS medical consultant]:

[Text deleted] is a medical consultant for MPIC's HCS team. He reviewed the Appellant's file and provided reports dated November 28, 2008, January 25, 2010, November 21, 2011, October 17, 2012, October 9, 2013, October 31, 2016, January 24, 2018 and September 9, 2019. He testified at the appeal hearing and was qualified as an expert in sports medicine, with a specialty in forensic file review.

He described his forensic review of the Appellant's file, and his process for conducting an analysis of whether a causal connection existed between her injuries and the MVA. This involved a review of the mechanism of injury, as well a consideration of how the Appellant presented after the MVA and her progress thereafter. He did not meet the Appellant, but he was able to get sufficient data from all of the information that she provided to the case manager and all of her caregivers. He concluded that the Appellant's symptoms were not a medically probable outcome of the MVA.

[MPIC's HCS medical consultant] noted that although there was an impact in the MVA, it did not appear to be significant, and the Appellant did not attend on any health care providers that day. She had a soft tissue sprain, went for physiotherapy treatment, and then got better with time and returned to her previous level of function, which is the natural history for that condition. When things changed in 2007, and other symptoms developed, he saw no evidence to connect those symptoms to the MVA. He said that a soft tissue sprain is the most common problem that he sees in his clinical practice, and he sees it a lot in MPIC file reviews, arising from rear-end collisions and whiplash. When referring to the natural history of the condition, he explained that with a minor injury, such as this, it will settle down, and the timeframe would be anywhere from a week to a few months. Sometimes things change, and improvement is not progressing, or new findings come up, and further investigation is warranted. But in his view, that wasn't the case for the Appellant, as she was progressing. Then a new issue arose, a gastrointestinal matter. [MPIC's HCS medical consultant] said he cannot see a connection

from her gastrointestinal issues to the MVA, nor can he see any connection between the investigations done years later with respect to her spine and the MVA, because he cannot identify any pathology that may have been missed. If the MVA injury was severe, you would know within a day or so.

[MPIC's HCS medical consultant] was asked to comment on [sports medicine physician]'s diagnosis of the Appellant's condition as being somatic or functional in nature. He did not disagree with [sports medicine physician] that the Appellant's presentation since 2008 has been somatoform; her symptoms are numerous, including gastrointestinal and pain, impacting her quality of life, and a probable physical cause cannot be determined, so this is the diagnosis. However, [MPIC's HCS medical consultant] did not agree with [sports medicine physician] that the Appellant's somatoform condition was caused by the MVA. He said that although it is reasonable for [sports medicine physician] to want to be supportive of his patient, he is not sure that [sports medicine physician] had access to all of the evidence that he has access to; [MPIC's HCS medical consultant] gives his opinion based on the documents that he reviews.

In [MPIC's HCS medical consultant]'s opinion, the Appellant's soft tissue sprain was much improved at the end of 2006. When she presented with nausea and gastrointestinal issues in early 2007, these were different symptoms, not connected to her earlier back and neck pain. Similarly, when she later had significant functional decline, these later symptoms were not connected to her initial back and neck problems. Although the Appellant did initially mention that she had nausea to the case manager, there was only one mention of this until 2007, and this does not support the connection of the later gastrointestinal symptoms to the MVA. The July 25, 2013, acupuncturist's letter, which mentions treatment for back and neck pain in early 2007, did not impact his opinion on causation. Although the letter is a statement of care provided, in his view, it would have more weight if clinical notes were provided and if physical findings were outlined. From other reports on the file, there is no indication

that the Appellant was experiencing neck and back pain during this time, and he would put more weight on those reports. In [MPIC's HCS medical consultant]'s view, it is not probable that a person would have an improving soft tissue injury, and then a later gastrointestinal condition that would be causally connected to that injury. He has never seen that in his practice.

The Appellant sought chiropractic treatment in July, 2007, for symptoms including headaches, back pain and digestive pain. [MPIC's HCS medical consultant] said this did not impact his causal connection assessment. He said that this does not reflect a recurrence of the Appellant's MVA injuries; rather, there had been a new, challenging, gastrointestinal incident, which led to nonspecific symptoms. Lower back pain is very common. According to the discharge report after physiotherapy, her back pain had resolved, and then she had been subject to significant gastrointestinal issues. In addition, according to her own report, the vacuuming incident in June, 2007, had some impact on her health. He agreed with the conclusions provided by the HCS medical consultant, [text deleted], in his reports dated December 11, 2014, and May 27 2015, that the Appellant's medical condition was not caused by the MVA.

[MPIC's HCS medical consultant] did not agree that the Appellant could have sustained a craniocervical injury in the MVA. This kind of injury would create an instability where the neck meets the head, and is significant, to the extent that it may be life-threatening. Having reviewed all of the reports on file, [MPIC's HCS medical consultant] said that it is not plausible to him that the Appellant could have sustained this kind of damage to multiple ligaments, and yet not have any symptoms for a day or two after the MVA. She was seen by many health care providers who did not assess this kind of injury for years, and even now, one health care provider who has reviewed the new imaging does not agree with the assessment. Although her treating chiropractor has said that the trauma of the MVA was latent, and the damage showed up with further activity, [MPIC's HCS

medical consultant] said that based on his experience, where someone has damage to multiple ligaments, it would be very painful right from the beginning, and so this does not make sense.

On cross-examination, [MPIC's HCS medical consultant] discussed his experience with soft tissue injuries and causation reviews. He spends two days each week in private practice, and two days working for MPIC. He has done hundreds, or perhaps thousands, of causation reviews. In his causal connection analysis, one thing that he considers is the impact of the injury on function, including ability to work, and quality of life. He has treated many soft tissue injuries, and would expect most people to recover. He acknowledged that some people don't follow that expected progress. Sometimes people can't cope, and they decompensate physically and psychologically, or sometimes it's a bad outcome. He acknowledged that a somatoform disorder, where a person focuses on their symptoms, and then manifests new ones, could develop as a result of an MVA, due to a person's inability to cope with their MVA injuries. On redirect, [MPIC's HCS medical consultant] said that he does not link the Appellant's somatoform disorder to the MVA here, because there was so much else going on after the MVA that would have contributed to the many symptoms the Appellant developed, especially her gastrointestinal issues. In his opinion, it was the Appellant's gastrointestinal issues that were key to the development of her somatoform disorder. Also on redirect, [MPIC's HCS medical consultant] said that the result of the MVA here was not a bad outcome; on the contrary, the Appellant had a good outcome. She had treatment and improvement occurred, and she went on to resume function. Subsequently, she developed other conditions that resulted in 19 different diagnoses, but those are not related to the MVA.

Cross-examination reviewed the Appellant's MVA injuries and her discharge from physiotherapy in December, 2006. [MPIC's HCS medical consultant] agreed that following the MVA, the Appellant complained of neck pain and low and mid back pain. He acknowledged that she complained of nausea once or perhaps twice following the MVA. Based on his review of her discharge from physiotherapy,

he concluded that the Appellant's thoracic and lumbar issues had resolved, but some neck symptoms remained. Her self-assessment tool, with numeric pain ratings, still showed some impairment. The reason for discharge was that the maximum number of sessions had been reached. The Appellant was given home exercises, which is something that he considers appropriate, in order to encourage her to become independent. On redirect, [MPIC's HCS medical consultant] said that in his experience, if the physiotherapist feels that the patient's issues are not resolved and more treatments are required, they will ask MPIC for more treatment. That did not happen here. The physiotherapist indicated that the Appellant was discharged with instructions for home exercises. [MPIC's HCS medical consultant] said that the self-assessment tools are subjective, and are an indication of how a patient perceives themselves. On his review, there was not much of significance noted in the physiotherapy discharge report, except for loss of mobility in the Appellant's neck.

On cross-examination, [MPIC's HCS medical consultant] said there was nothing on file to confirm the Appellant's testimony that the home exercises became more difficult for her over time, nor were there any clinical assessments where she reported that something was interfering with the resolution of her symptoms following her discharge from physiotherapy. When asked whether her attendance at the acupuncturist was evidence that her recovery was not going as planned, [MPIC's HCS medical consultant] said he was uncertain whether that attendance would have been for treatment for her nausea and vomiting, given that she was having those symptoms in early 2007. He said it was difficult to assess without further information from the acupuncturist. There is nothing from a medical perspective that would link her nausea and vomiting to a soft tissue injury. In his experience, the nausea and vomiting could have caused her back pain; vomiting is a physically challenging event, which causes every muscle in the body to tense. [MPIC's HCS medical consultant] acknowledged that the Appellant did not report that her back pain got worse due to vomiting. He did not agree that

soft tissue pain could cause vomiting, although he did accept that severe pain with radiculopathy could cause someone to vomit, and also certain medications can cause vomiting.

[MPIC's HCS medical consultant] was questioned as to whether back pain caused by the MVA could be resolved, but then could recur and worsen. He said that if the back problem resolved, it would not be probable that subsequent back pain would be linked to the earlier problem. The subsequent back pain would more probably be because of another event, or even not linked to any event. On redirect, [MPIC's HCS medical consultant] said that in an MVA, where there is an alteration of the spine, like a disc injury, you may be able to relate subsequent back pain to the original injury. But where, as here, there was no alteration to the spine, and it was a soft tissue injury, it is not reasonable to relate subsequent back pain to the MVA, especially since it was a minor injury, and the Appellant's back pain had resolved.

On cross-examination, [MPIC's HCS medical consultant] agreed that one factor in his assessment that the Appellant's symptoms were not caused by the MVA is that she had been able to return to her pre-MVA work capacity. [MPIC's HCS medical consultant] agreed that working at full capacity means the ability to do all duties. He noted that there was no documentation of any restriction in the Appellant's duties when she returned to work in October, 2006. He did not agree that the letter dated June 12, 2013, from the Appellant's co-worker suggested that the Appellant's recovery did not go as hoped, because it was not possible to pinpoint the period of time to which the comments in the letter refer. The comments do not correlate to clinical notes of the Appellant's practitioners. Counsel noted that the Appellant testified that she has not returned to her pre-MVA level of recreational and social activity. When asked whether the inability to resume her pre-MVA activities is evidence that the Appellant's recovery has not gone well, [MPIC's HCS medical consultant] said that in the absence of other evidence, that would be the case. However, here there is other evidence, most significantly

the gastrointestinal issues that the Appellant suffered in early 2007, as well as, to a lesser extent, the vacuuming incident in June, 2007. He said that while the vacuuming incident would have caused the Appellant some new back problems, and was an intervening event, he would have expected her to heal relatively quickly, and he would not have expected a long-term recovery. [MPIC's HCS medical consultant] said that when the Appellant sought chiropractic treatment in July, 2007, although her symptoms were similar to those she experienced following the MVA, these symptoms were nonspecific, and could have been the result of doing daily activities.

When questioned regarding the diagnosis of CCI, [MPIC's HCS medical consultant] said that it is one of the 19 different diagnoses that the Appellant has been given over the years, and he does not agree with it. He said that if the Appellant had had the amount of ligament damage suggested, she would not have been able to get out of the car; she would have been in a neck collar, and taken to the hospital. He does not agree with the reports of [Appellant's consulting chiropractor] and [Appellant's treating chiropractor], because they do not provide a plausible explanation for how the Appellant could present one way after the MVA, and differently now. They relate her presentation to an MVA which they say was severe, but the MVA was not severe. They would seem to suggest that the Appellant had a high pain threshold, but she does not. In [MPIC's HCS medical consultant]'s view, this diagnosis requires significant trauma, which did not exist here. While the Appellant said that the stem cell treatment is the only treatment that has given her any long-term relief, [MPIC's HCS medical consultant] questioned whether she is functionally getting better, because she has not returned to work. Although she may feel better, that is not evidence that the diagnosis is correct. While the treatment could be providing some relief, there is also the possibility of the placebo effect. In his view, looking at the totality of evidence, there is no possible way that significant ligament damage occurred in this MVA. [MPIC's HCS medical consultant] acknowledged that he is not an expert on CCI.

Submission for the Appellant:

Counsel for the Appellant noted that the issue for determination in this appeal is a factual one, being whether the Appellant's medical condition is causally connected to the MVA. He noted that essentially, this will require a finding that the symptoms experienced by the Appellant in early 2007 and into 2008 were caused by the MVA. He submitted that the panel is not required to make a determination as to the correct diagnosis of the Appellant's medical condition, particularly given that there is no agreement among her physicians; rather, the panel simply has to determine whether the condition from which she is suffering was caused by the MVA.

The critical evidence in this regard has been from the Appellant, who was a credible and reliable witness. In addition, the Appellant's health care providers gave evidence on her behalf, and they met with her, interacted with her and treated her. Counsel submitted that more weight should be given to the evidence of the Appellant's treating practitioners than to the evidence of [MPIC's HCS medical consultant], who only conducted a file review. [MPIC's HCS medical consultant] said that because [sports medicine physician] was her treating practitioner, he was more likely to advocate for his patient. Counsel submitted that [MPIC's HCS medical consultant] has more potential for bias than the Appellant's treating physicians, as he has spent 25 years and half of his working time conducting file reviews for MPIC. He did not have the opportunity to meet the Appellant and does not have any context to understand her functionality.

There is no dispute that prior to the MVA, the Appellant led a full and active life. She had a full-time job, and had an active social and recreational life, travelling and spending time with family and friends. She had some pre-existing TMJ and anxiety, but nothing that interfered with her ability to carry on her daily activities. All of this changed with the MVA. She was stopped at a red light and was rear-ended. A few days later she got really sore, with initial complaints of neck pain, mid and

low back pain, nausea, TMJ pain and headaches. She had 26 physiotherapy treatments which addressed those symptoms. She missed a few days of work, returning initially part-time and then full-time by mid-October, 2006. On her discharge from physiotherapy in December, 2006, although she was much improved, it is important to note that her condition was not resolved. She still had headaches, neck stiffness, and decreased glide at her upper spine. She was still reporting pain and moderate disability. Although the Appellant felt she would improve, and embarked on a home exercise program as recommended by her physiotherapist, she did not improve, and things started to get worse for her. In early 2007, she sought out acupuncture and massage therapy. Her nausea and vomiting started to get worse, and she went to see her general practitioner. Although MPIC has tried to downplay the July, 2013, letter from the acupuncturist, the letter says that he saw the Appellant from February through December, 2007, for neck and back pain, as well as for nausea and vomiting, which is in accord with the evidence of the Appellant. MPIC says her gastrointestinal issues are not related to the MVA, and is asking the panel to believe that the Appellant suffered from bad luck a few months after her discharge from physiotherapy, when a completely new condition arose. It is the Appellant's submission that the nausea was a continuing condition caused by the MVA that got worse, not a new event, although it was not that significant initially.

When the Appellant returned to work, in October, 2006, although she was working full-time, she was not fully functioning. The June, 2013, letter from her co-worker is evidence of the Appellant's performance at work before and after the MVA, from someone who was working with her. Counsel noted that [MPIC's HCS medical consultant] said that it is important to look at the Appellant's ability to function. The Appellant's difficulties at work, taken together with the fact that she never returned to her pre-MVA social and recreational activities, is evidence that the Appellant's recovery did not go as expected.

The Appellant testified that when her back pain was at its worst, that was when her nausea was the worst. Counsel submitted that [MPIC's HCS medical consultant]'s view that her back pain could have been triggered by the nausea or vomiting was pure speculation. There was no evidence of this. Counsel argued that if the Appellant had observed that her symptoms got worse because of vomiting, she would have said so, as she did with the vacuuming. Counsel noted that the Appellant reported to MPIC that the vacuuming incident made her symptoms worse; it did not create new symptoms. The Appellant went for chiropractic treatment in July, 2007, complaining of the very same symptoms that she had complained of following the MVA, that is, headache, low and upper back pain, jaw pain and digestive issues. Counsel submitted that what is most likely is that the Appellant was discharged from physiotherapy and then subsequently got worse. Although MPIC would ask the panel to believe that the Appellant's symptoms in July, 2007, were not caused by the MVA, or were connected to the Appellant's gastrointestinal issues which were not caused by the MVA, counsel argued that it is more plausible that these symptoms were caused by the MVA.

The Appellant continued to seek treatment for her medical condition, and it was not until much later that she received the diagnosis of CCI. Counsel submitted that the opinion of [MPIC's HCS medical consultant], who did not agree with that diagnosis, should be weighed against the opinion of [Appellant's treating chiropractor] and of [Appellant's consulting chiropractor], who actually has experience with this diagnosis, and who repeated the measurements of the Appellant's imaging report. [Appellant's consulting chiropractor] and [Appellant's treating chiropractor] agreed with [MPIC's HCS medical consultant] that trauma is required for this diagnosis, but is a question of degree. It depends on what position the victim's head is in. This diagnosis explains the delay, the Appellant's initial improvements, and her nausea and vomiting. She has seen some improvement from her treatment for CCI. Counsel acknowledged that some medical practitioners had different opinions regarding CCI, but argued that this is not the first time that medical practitioners have had

different opinions regarding a condition, for example PTSD, fibromyalgia and Lyme disease. He submitted that it could be possible that in a few years, CCI might be generally accepted by practitioners like [sports medicine physician] and [MPIC's HCS medical consultant].

In any event, it is not necessary for the panel to decide the diagnosis of the Appellant's medical condition. Counsel submitted that what makes the most sense is that the Appellant suffered trauma in the MVA, showed initial improvement, but then things progressively got worse. Whether the Appellant had a bad outcome, or a somatoform disorder, or CCI, it doesn't matter, because her symptoms didn't resolve. The Appellant's treating physicians all agree that the MVA caused her medical condition, even if they don't agree on the diagnosis. Therefore, the Appellant's appeal should be allowed.

Submission for MPIC:

Counsel for MPIC agreed that the issue for determination in this appeal is a factual one, on the narrow issue of causation. It is MPIC's position that the Appellant's medical condition was not caused by the MVA. After reviewing the relevant legislation (set out above), counsel submitted that the panel will have to determine the Appellant's MVA injury, and how that injury produced the results alleged by the Appellant. MPIC submitted that the Appellant's MVA injury was a minor soft tissue injury to the spine and neck, and that her subsequent medical condition is not related to the MVA injury. MPIC argued that on behalf of the Appellant, the only true analysis was from [sports medicine physician], which should be given less weight than the analysis of [MPIC's HCS medical consultant], whose analysis involved a forensic review of all of the medical evidence.

The circumstances of the MVA are not in dispute. The Appellant said she felt fine until two mornings later, when she had back and neck pain, and felt nauseous. On September 19, 2006, she went to physiotherapy, and was assessed with cervical and lumbar strain. MPIC approved 26 physiotherapy sessions. The Appellant took a few days off of work, and eventually went to part-time hours, working three hours daily instead of her regular 5 ½ hours. MPIC provided income replacement top up, which ended when she returned to full-time work on October 19, 2006. Her physiotherapy continued until December 5, 2006, 2 to 3 times per week.

Throughout this period of time, the Appellant appeared to be able to participate in social activities, attending two weddings, and tapering off her attendance at physiotherapy near the end. Although she said perhaps she was too sick to attend, the physiotherapist's chart note on November 30, 2006, said that she was "too busy", and that she had "0 difficulties at work". In addition, she was also seeing [Appellant's physician] during this time, and that doctor's chart notes reflect her improvement during this time period. Counsel submitted that looking at the time from when the Appellant returned to full-time work on October 19, 2006, until her discharge from physiotherapy on December 5, 2006, it is significant that there is no documentation in her caregivers' chart notes of any difficulties at work, but rather the opposite. This contradicts the Appellant's argument, and puts into question [sports medicine physician]'s testimony, that the Appellant deteriorated with normal activity. The totality of the evidence suggests that as of October 19, 2006, the Appellant was able to resume her normal life, and while her symptoms were not completely resolved, they did not deteriorate. This is consistent with the physiotherapy Discharge Report, which documents low and improved pain scores, and reflects that the Appellant was back at work, with no modified or restricted duties, and no request for additional treatment.

It is MPIC's position that the Appellant subsequently developed gastrointestinal difficulties, unrelated to the MVA. On February 6, 2007, the Appellant went to see [Appellant's physician]. She identified the reason for that visit as food poisoning with vomiting two months previously. There was no mention of neck or back pain on that visit, nor on the next two visits. [Appellant's physician] was of the view that the Appellant's gastrointestinal issues were unrelated to the MVA, as she stated in her report dated June 5, 2009. The Appellant was clearly experiencing significant gastrointestinal issues, visiting multiple hospitals in May and June, 2007, having an ultrasound and an x-ray, and ultimately being referred to [text deleted], a gastroenterologist. In all of the documents from these hospital visits, there is no mention of back or neck pain.

While the Appellant did present with back pain when she sought chiropractic treatment in July, 2007, it is MPIC's position that this back pain could have been caused by the June, 2007, vacuuming incident, or could have been nonspecific in nature. [Text deleted], an HCS chiropractic consultant, in his report dated August 20, 2007, stated as follows:

> In my opinion the claimant had adequate treatment through physiotherapy. She appears to have made a good recovery. The symptoms experienced in June 2006 [2007] following vacuuming are common in the general population, including those with and without trauma, and closely followed the physical activity of vacuuming. In my opinion these are unrelated to the motor vehicle accident in the balance of probabilities.

Counsel noted that the Appellant's symptoms listed on the Initial Chiropractic Report dated July 30, 2007, while similar in some respects, were not exactly the same as those that she presented with immediately following the MVA. In particular, digestive pain, which was rated highest by the Appellant, at 10/10, and diaphragm spasm, were not listed on the Initial Therapy Report of the physiotherapist dated September 21, 2006. It is also important to note that the Appellant had continued to work full-time from October 19, 2006, until February, 2008. Various imaging done of the Appellant's spine revealed no abnormalities, and a bone scan was also normal. A consultation

with a neurologist, [text deleted], on July 30, 2008, revealed no evidence of an organic basis for any of her symptoms. Although the Appellant's treating physician, [sports medicine physician], concluded that the MVA was the most likely cause of her condition, this was based on his assessment that there been a continuity of her symptoms since the MVA, and MPIC disputes this. [Sports medicine physician] also relied on the report of [specialist] dated November 25, 2008 (revised January 29, 2009). Counsel submitted that [specialist] based his report primarily on the subjective reporting of the Appellant, and was not accurate, and therefore should be given less weight; consequently, the conclusions of [sports medicine physician] should be given less weight.

Counsel argued that there is a gap in the continuity of the Appellant's reporting of her neck and back symptoms, in that from her discharge from physiotherapy in December, 2006, through to July, 2007, the Appellant was not reporting those symptoms to [Appellant's physician], to MPIC, or to her physiotherapist. Counsel submitted that although the Appellant testified at the hearing regarding her symptoms during that time period, the best evidence would be found in documents prepared contemporaneously, and those documents do not reflect that she was reporting back or neck pain. That is not to impugn the Appellant in any way; rather, MPIC is simply pointing out that it is reasonable that over the 15 years since the MVA, someone might get the facts wrong. In order to weigh the Appellant's evidence, it is necessary to determine whether it is reliable, and review any inconsistencies. For example, the Appellant said that it was difficult for her to do her work duties following her discharge from physiotherapy; however, she had been working full-time for six weeks prior to her discharge, and had not described any work difficulties, and in fact her physiotherapist's chart notes indicate that she was not having any difficulty at work. Counsel submitted that the June 12, 2013, letter from the Appellant's co-worker, obtained at the suggestion of her former counsel, should not be given much weight. Although it mentions the Appellant's difficulty at work subsequent to the MVA, it does not account for admitted periods when the Appellant was doing better. It is

therefore not clear whether the letter is intended to refer to the time immediately following the MVA, or perhaps during the Appellant's gastrointestinal difficulties; since the letter was written in 2013, it is not as reliable as something produced contemporaneously. Counsel also submitted that the July 25, 2013, letter from the acupuncturist, produced in the context of the appeal, should be given little weight. Although that letter says that treatments were provided to the Appellant for areas including neck and back pain, there are no accompanying chart notes. Health Care Services raised the concern regarding the absence of chart notes in 2014, allowing time for clarification to be provided, but it was not. MPIC submits that documentation provided contemporaneously is more important and reflective of what was happening at the time, whereas later documents have a secondary motive connected with the MPIC claim.

Regarding the diagnosis of CCI, [MPIC's HCS medical consultant] strongly refuted that this could be related to the MVA. He said that an injury of this nature would have made itself apparent within a few hours after the MVA. [Appellant's treating chiropractor] didn't see any problems with the Appellant's neck when he was initially treating her. He has never previously treated a person with this condition, and he only educated himself on CCI when the Appellant brought him the information. [Appellant's consulting chiropractor], when pressed, admitted that the Appellant's situation is confounding. Even [sports medicine physician], the Appellant's treating physician since 2008, does not agree with the diagnosis of CCI. It is MPIC's position that a finding that the MVA caused CCI cannot be established.

Counsel submitted that the evidence of the HCS consultants should be preferred over the evidence of [sports medicine physician]. [Sports medicine physician], in his February 17, 2014, report, produced at the request of the Appellant's former counsel, relied on the report of [specialist], and the letter from the acupuncturist. However, [specialist]'s report itself is based primarily on the Appellant's

subjective reports, and the acupuncturist's letter is not reliable; therefore, [sports medicine physician]'s report should be given less weight. It is not clear what documents [sports medicine physician] reviewed in making his report. The HCS medical consultant [MPIC's HCS medical consultant #2], in contrast, provided a comprehensive review dated December 11, 2014, and therefore should be given greater weight. [Sports medicine physician] agreed that the conclusions reached by [MPIC's HCS medical consultant] in his January 24, 2018, report were reasonable. [MPIC's HCS medical consultant], in his testimony, provided a good explanation of why there is no causal connection here. Although there are some cases where patients have a bad outcome, that was not the case here. Here, the Appellant had a good outcome: she went to treatment, she got better, and then she returned to work. What happened afterwards, her gastrointestinal issues and somatoform disorder, were unrelated to the MVA; a bad outcome, but not related to the MVA.

It is MPIC's submission that the injury suffered by the Appellant in the MVA was a soft tissue injury, for which she sought treatment and which resolved by December, 2006. The Appellant subsequently had a new, unrelated medical problem, gastrointestinal issues, which cannot be linked to the MVA. Unfortunately, the Appellant then developed a somatoform disorder, but this was not caused by the MVA. Counsel recognized that the Appellant has significant issues; however, he submitted that on the preponderance of evidence, the MVA did not cause those issues. MPIC therefore submits that the appeal ought to be dismissed.

Discussion:

The onus is on the Appellant to show, on a balance of probabilities, that her medical condition is causally connected to the MVA. There is no dispute that the Appellant suffered a bodily injury in the MVA, within the meaning of subsection 70(1) of the MPIC Act, as set out above. Further, there is no dispute between the parties that, at present, the Appellant is suffering from diverse and significant symptoms, although not all medical practitioners agree on the cause or diagnosis of her medical

condition. The dispute is whether the Appellant's MVA injury led to her medical condition, or, in other words, whether there is a causal connection between the Appellant's MVA injury and her medical condition. The onus is on the Appellant to show that there is.

The initial injuries reported by the Appellant following the MVA were back and neck pain, and that she felt nauseous. [Appellant's physician]'s chart note of September 19, 2006, records those symptoms. [Appellant's physician] referred the Appellant to physiotherapist [text deleted], who reported to [Appellant's physician] on September 30, 2006, that she assessed the Appellant with "cervical & lumbar whiplash associated strain". The Appellant saw [Appellant's physician] three times in October and November, 2006. [Appellant's physician]'s chart note of November 7, 2006, records that the Appellant was working full-time and was "much improved". The Appellant was also reported by her physiotherapist to be "much improved" upon her discharge from physiotherapy on December 5, 2006.

The Appellant testified that although she was working, it was very hard for her. Her back and neck pain continued following her discharge from physiotherapy. She said that she sought treatment through massage therapy and acupuncture beginning in February 2007. It was also her testimony that her bouts of vomiting began around November, 2006. She said that these incidents progressed in frequency, and she eventually felt that she should seek medical care.

It is the Appellant's position that her back and neck pain were not resolved following her discharge from physiotherapy in December, 2006, but continued thereafter, and in fact got worse. In addition, it is the Appellant's position that her nausea was a continuing condition caused by the MVA that got worse, and thus the significant gastrointestinal issues that she experienced were caused by the MVA. The Appellant argues that her medical condition, encompassing her back and neck pain and her

gastrointestinal issues, is causally connected to the MVA. The Appellant relies on the evidence of the [sports medicine physician], who attributes her medical condition to the diagnosis of somatic symptom disorder, and on the evidence of [Appellant's consulting chiropractor] and [Appellant's treating chiropractor], who attribute her medical condition to the diagnosis of CCI/CTE.

It is MPIC's position that the Appellant's MVA injury resolved upon her discharge from physiotherapy, or shortly thereafter. MPIC argues that the Appellant's subsequent medical condition, including her gastrointestinal issues and also her somatic symptom disorder, was not caused by the MVA. MPIC relies on the evidence of [MPIC's HCS medical consultant] in this regard.

Back and Neck Pain

As noted above, the Appellant testified that her back and neck pain continued following her discharge from physiotherapy. Counsel for MPIC argued that the Appellant's testimony regarding the continuity of her back and neck pain was unreliable, given the length of time that has passed since the events in question. In addition, he argued that the contemporaneous documentary evidence does not support the Appellant's testimony.

The panel has carefully considered the evidence, and we find that it does not support the Appellant's testimony, for the following reasons:

- Physiotherapist [text deleted], in the Discharge Report dated December 5, 2006, indicated that the Appellant had some symptoms remaining, identified as "occasional headaches & neck stiffness", with decreased glide at the upper cervical spine. However, objective signs indicated no thoracic findings and no lumbar findings. Therefore, while it is clear that the Appellant had some neck symptoms remaining on discharge, it is also clear that there were no objective

back findings on discharge. Although the Discharge Report did note that the Appellant reported subjective complaints of pain, these were significantly lower than on her initial report (at discharge, overall pain was 3/10 vs. 10/10 initially, back pain was 6/24 vs. 16/24 initially, and neck pain was 19/50 vs. 35/50 initially).

- The Appellant returned to full-time work on October 19, 2006. She continued to work full-time from her return, continuing through the time of her discharge from physiotherapy, until February, 2008. Over this sixteen month period of time, there is no documentary evidence that the Appellant required any modification to her work duties (subject to our comments below regarding the co-worker's letter).

- The Appellant was seen by [Appellant's physician] on November 7, 2006. The chart notes from that visit indicate that she advised the doctor that she was feeling much improved and had returned to full-time work. She was advised to return in 4 to 6 weeks for follow-up. It appears that she did not do so.

- [Physiotherapist] noted in her chart on November 30, 2006, that the Appellant reported "0 difficulties at work". Neither [Appellant's physician] nor [physiotherapist] imposed any modification to the Appellant's work duties.

- There is an MPIC file record dated December 19, 2006, which notes that the Appellant left a message regarding the status of her treatments and injuries. The record states, in part, as follows: "She stated that she just completed her tx's [treatments] a week ago and that she is doing fine".

- There is no record in MPIC's file that the Appellant contacted MPIC at any time after December 19, 2006, until July 30, 2007, when a file note records that she contacted MPIC to

request coverage for chiropractic treatment for back pain. The Appellant said that she was vacuuming about a month earlier and her back was very sore. While it appears that she had not been in contact with the case manager for seven months, she advised the case manager that these were the same symptoms "from the onset of the claim".

- The Appellant attended at [Appellant's physician] on six occasions from February, 2007, through the end of July, 2007. In the chart notes for the five visits from February through June, there is no notation regarding back or neck pain. Although the Appellant testified that she told [Appellant's physician] in February, 2007, that she had back and neck pain, there is no record of this in [Appellant's physician]'s chart notes. The first mention of back pain in the chart notes is on July 23, 2007, where is it recorded that the Appellant complained of "low back pain / since MVA".

- The Appellant attended at the [health centre] in May, 2007, the [hospital] emergency room in May, 2007, and [hospital #2] emergency room in June, 2007, and there does not appear to be any mention in those records regarding back or neck pain.

- The Appellant's co-worker, [text deleted], who worked with the Appellant until June, 2007, provided a letter dated June 12, 2013. The letter says that she noticed changes in the Appellant "following her 2006 motor vehicle accident", and that the Appellant complained of back and neck pain and had difficulty sitting, requiring her to bring in pillows to work for support. She noted that "this continued long after her accident". We note that this letter was produced in the context of the appeal, six years after the time to which it refers. It is not specific with respect to time, and does not account for the periods when the Appellant acknowledged that she was doing better, such as following physiotherapy. We are of the view that this letter is

not as reliable as something produced contemporaneously, and accordingly assign little weight to it.

- A July 25, 2013, letter from [acupuncture clinic], stating that treatments were provided to the Appellant from February to December, 2007 for her "upper, lower, mid back pain, headaches and neck pain", and noting that she complained of severe headaches and severe back pain, as well as nausea and vomiting at the time. We note that this letter was also produced in the context of the appeal, six years after the time to which it refers. While this letter says that treatments were provided to the Appellant for areas including back and neck pain, there are no contemporaneous clinic notes from this health care provider. We are of the view that this letter is not as reliable as something produced contemporaneously, and accordingly assign little weight to it.

As indicated, we view contemporaneous documentary evidence as much more likely to be reliable than documentary evidence created subsequently. Similarly, in the face of a conflict between the contemporaneous documentary evidence and the Appellant's recollection, we consider the contemporaneous documentary evidence as much more likely to be reliable.

A summary of the contemporaneous documentary evidence outlined above reveals that by the time of her discharge from physiotherapy, the Appellant's MVA injury was much improved. Although she was found to have neck stiffness, her pain complaints had decreased. She was working full-time, and was able to do so, with no modification imposed to her duties, until February, 2008. There is no contemporaneous documentary evidence that the Appellant had any back or neck pain following her discharge from physiotherapy until [Appellant's physician]'s July 23, 2007, chart notation of back pain, and then on July 30, 2007, when an MPIC file note records that she contacted MPIC to request

coverage for chiropractic treatment for back pain. In both of those notes, there is reference to the Appellant having said that she had back pain since the time of the MVA. As indicated above, and while bearing in mind what those notes state that the Appellant had said, we conclude that the contemporaneous documentary evidence does not support the Appellant's testimony that her back and neck pain continued following her discharge from physiotherapy. Therefore, we find that the Appellant has not met the onus of establishing, on a balance of probabilities, that her back and neck pain continued following her discharge from physiotherapy on December 5, 2006.

Somatic Symptom Disorder

The Appellant's treating sports medicine physician, [text deleted] MVA injury to her neck and back developed into a somatic symptom disorder, which was caused by the MVA. He said that his opinion was based on the continuity of the Appellant's symptoms from the MVA to date. He provided the following assessment in his report dated May 27, 2008:

> She described that she was involved in a motor vehicle accident in September 2006 in which she had noted low back and cervical-based pain since that time. […]
>
> At present, it is my opinion that [the Appellant]'s low back and mid back pain are a result of her motor vehicle accident given the continuation of symptoms and no previous pre-existing pathologies to the lumbo-thoracic region. […]

In his report dated February 17, 2014, [sports medicine physician] stated as follows:

> […] [the Appellant]'s complaints, at their current level and since 2008, would be classified as a somatic or functional-based diagnosis […]
>
> […]
>
> […] it is the writer's opinion that the symptoms documented as part of [the Appellant]'s presentation post-MVA in 2006, were ongoing in early 2007 and have been ongoing to date. Therefore, if the presentation post-MVA in late 2006 was felt to be related to the motor vehicle accident, then its continuation through 2007 to current would also be on the probable basis of the motor vehicle accident, given the relative consistency of symptoms, signs/presentation and no other medical condition being present to better explain her presentation from a medical perspective.

As noted, [sports medicine physician] first saw the Appellant in April, 2008, nineteen months after the MVA. Although he has been her treating physician since that time, it was necessary for him to rely on the Appellant's subjective reporting as to her history prior to her first visit. In his 2014 report, [sports medicine physician] also relied on the report of [specialist] dated November 25, 2008 (revised January 29, 2009), who saw the Appellant on one occasion, more than two years after the MVA, and who also relied on the Appellant's subjective reporting as to her prior history. As indicated above, we have found that the Appellant has not established that her back and neck pain continued following her discharge from physiotherapy in December, 2006. Therefore, given that [sports medicine physician]'s opinion regarding the causation of the Appellant's somatic symptom disorder relies on the continuity of her back and neck symptoms from the MVA to date, we have given it less weight.

In contrast, [MPIC's HCS medical consultant]'s opinion was that he could not causally connect the Appellant's medical condition to the MVA, because her MVA injury had resolved following physiotherapy, and any medical condition arising after that was not caused by the MVA. [MPIC's HCS medical consultant]'s evidence was that the Appellant's soft tissue sprain resolved following her discharge from physiotherapy, which he said is the natural history for that condition. He stated in his report dated October 9, 2013:

> […] The medical evidence recently obtained from [physiotherapy clinic] and [Appellant's physician] clearly outlines significant subjective and functional improvement in [the Appellant]'s condition after the incident in question as of November and December 2006. […]

He stated further, in his report dated January 24, 2018:

> The evidence indicates [the Appellant] was able to return to work, following the documented improvement, and resume the work capacity she was performing prior to the incident in question (this indicates the restoration of occupational function, which is the common sequelae following a mild to moderate soft tissue strain/sprain).

In [MPIC's HCS medical consultant]'s view, the Appellant's MVA injury improved, and a new issue arose, being the gastrointestinal issue. He saw no causal connection between that condition and the MVA (this is discussed further below). [MPIC's HCS medical consultant] did not disagree with [sports medicine physician] that the Appellant's presentation since 2008 has been somatoform, in that she has numerous symptoms, including gastrointestinal and pain, for which a probable physical cause cannot be determined. However, he was of the opinion that the Appellant's somatic symptom disorder was not caused by the MVA. [MPIC's HCS medical consultant] stated as follows, in his report dated September 9, 2019:

> Symptoms [the Appellant] might be experiencing at this time are not a medically probable outcome of the incident in question.

The panel finds that [MPIC's HCS medical consultant], in the preparation of his reports, had the opportunity to review all of the medical reports, assessments and reports of interventions on the Appellant's file and was thorough and comprehensive in his analysis. Where their evidence conflicted, the panel preferred the evidence provided by [MPIC's HCS medical consultant] to that of the Appellant, whose evidence was not consistent with the contemporaneous documentary evidence. Similarly, where there was a conflict between them, the panel preferred the evidence of [MPIC's HCS medical consultant] to that of [sports medicine physician]. While [sports medicine physician] said that he conducted an "extensive review" in preparing his report of February 17, 2014, the panel finds that this report is not comprehensive in its analysis. The report does not identify all of the documents which were reviewed in conducting the assessment, and it deals with only documents which are supportive of the Appellant's perspective, without addressing documents with a contrary perspective. In contrast, [MPIC's HCS medical consultant] produced analyses dealing with both sides of the issue.

Therefore, we find that the Appellant has not met the onus of establishing, on a balance of probabilities, that she suffers from a somatic symptom disorder that is causally connected to the MVA.

Gastrointestinal Issues

[MPIC's HCS medical consultant] said that the gastrointestinal issues experienced by the Appellant in 2007 were not connected to her neck and back pain. He noted that there was only one mention of nausea in the chart notes prior to February, 2007, and this supported his view that the gastrointestinal symptoms were not connected to the MVA. His opinion was that it was not probable that a person would have an improving soft tissue injury, and then later develop a gastrointestinal condition that was causally connected to it. He had never seen that in his years of practice.

The Appellant said that the significant gastrointestinal issues that she experienced in 2007 and thereafter were related to the nausea which she felt immediately following the MVA. She testified that she experienced some vomiting beginning in November, 2006. She said that these incidents progressed in frequency, and she eventually felt that she should seek medical care, when she went to see [Appellant's physician] regarding this issue in February, 2007.

In her Application for Compensation dated October 17, 2006, in addition to the injuries listed, it is recorded that the Appellant felt nauseous immediately following the MVA (this is reflected in the MPIC file note of the same date, when the Appellant met with the case manager to complete the Application). On September 19, 2006, three days following the MVA, the Appellant had gone to see [Appellant's physician] and then was referred for physiotherapy to [physiotherapist]. The chart notes of [Appellant's physician] from that visit record that the Appellant experienced "whiplash entire

back/neck, felt nauseous". The physiotherapist's note from September 19, 2006, also notes "some nausea, pt feels is due to TMJ".

Apart from the initial reports to [Appellant's physician] and [physiotherapist], which were made on the same day, there is nothing in the contemporaneous documentary evidence indicating that the Appellant reported any other episodes of nausea until her attendance at [Appellant's physician] on February 6, 2007; nor is there any contemporaneous documentary evidence that the Appellant experienced any bouts of vomiting or diarrhea prior her to reporting of such to [Appellant's physician] on that date.

On February 6, 2007, the Appellant visited [Appellant's physician] complaining of vomiting, which she attributed at that time to possible food poisoning that occurred two months earlier. The chart note records that the Appellant indicated that she was "vomiting 2 x per week". A chart note for a further visit on February 19, 2007, indicates that the "vomiting stopped".

The Appellant subsequently returned to [Appellant's physician] on May 22, May 31 and June 27, 2007, with further complaints of gastric issues. The documentary evidence from this time period indicates that the Appellant was experiencing gastrointestinal distress, as evidenced by the following hospital attendances:

- On May 23, 2007, the Appellant attended at the [health centre], complaining of abdominal pain. She was given instructions to return for an ultrasound on May 28, 2007.

- On May 25, 2007, the Appellant attended at the [hospital] emergency department complaining of vomiting and diarrhea. She was diagnosed with abdominal pain.

- On May 28, 2007, the Appellant returned to the [health centre] for an abdominal ultrasound, and was diagnosed with dyspepsia. She was prescribed medication.

- On June 20, 2006, an x-ray of the Appellant's esophagus, stomach and duodendum was taken, and all were normal in appearance.

- On June 27, 2007, the Appellant attended at the [hospital #2] emergency room, complaining of nausea and vomiting frequently for the last six weeks. An x-ray of her chest was taken, which was normal. She was diagnosed with epigastric pain.

- On July 2, 2007, an x-ray of the Appellant's abdomen was taken at [hospital #2], and no abnormalities were identified.

- On July 20, 2007, the Appellant underwent a gastroscopy procedure at [hospital #2] which revealed a small hiatus hernia.

We note that the Appellant's gastrointestinal issues have been diagnosed, and are being treated by, gastroenterologists. In her testimony, the Appellant said she had been seen by a gastroenterologist, [gastroenterologist #1], in late 2007, who diagnosed her with IBS, irritable bowel syndrome. While there is no report from [gastroenterologist #1] in evidence, HCS consultant [MPIC's HCS medical consultant #2], in his report dated December 11, 2014, confirmed that he had reviewed the notes of [gastroenterologist #1], "who opined that the diagnosis for the claimant's abdominal symptoms was Irritable Bowel Syndrome". The Appellant said that she continues to see [gastroenterologist #2], another gastroenterologist, who has been treating her since 2013 for that condition and prescribing medication to her. He has never indicated that he thinks her IBS was caused by the MVA.

Considering all of the evidence, we conclude that the Appellant has not established, on a balance of probabilities, that the nausea that she reported to her two health care providers on September 19, 2006, was a continuing medical condition that continued and/or developed into the nausea, vomiting and diarrhea for which she was widely investigated, and in respect of which she made multiple emergency room attendances in May and June, 2007 (and subsequently). The weight of the evidence supports the view that the Appellant's gastrointestinal issues, which are clearly significant, are very unlikely to have been a consequence of the MVA. We accept [MPIC's HCS medical consultant]'s evidence and opinion on this issue.

Therefore, we find that the Appellant has not met the onus of establishing, on a balance of probabilities, that the significant gastrointestinal issues that she experienced were caused by the MVA.

CCI/CTE

The Appellant argued that even if there was a delay, or a gap, in the continuity of her symptoms, her medical condition, encompassing her back and neck pain and her gastrointestinal issues, is nevertheless causally connected to the MVA. The Appellant relies on the evidence of [Appellant's consulting chiropractor] and [Appellant's treating chiropractor] in this regard. As noted above, in 2017, after reviewing [neurosurgeon]'s report and imaging obtained by the Appellant in 2016, [Appellant's consulting chiropractor] was of the opinion that the Appellant suffered significant alar ligament damage in the MVA, resulting in the diagnoses of CCI and CTE. In 2018, [Appellant's treating chiropractor], who reviewed her new imaging and conducted some research, agreed with this conclusion.

In contrast, [MPIC's HCS medical consultant] was of the opinion that the Appellant's MVA injury could not have been related to CCI. He said an injury of that nature would have made itself apparent within a few hours of the MVA, which was not the case here. In his report dated January 24, 2018, [MPIC's HCS medical consultant] stated as follows:

> [Appellant's consulting chiropractor] outlined that the findings on images establishes [the Appellant] sustained serious and permanent injuries at the craniocervical junction that have resulted in mechanical deformation of the brain and spinal cord (presently the BI3 claim does not contain evidence confirming brain deformity or structural changes to the spinal cord; evidence outlining the assessments [the Appellant] underwent shortly after the incident in question and her response to the treatment she received (i.e. much improved) logically rules out the development of serious and permanent injuries to the craniocervical junction, in my opinion).

In his report dated September 9, 2019, [MPIC's HCS medical consultant] stated:

> The evidence does not support the position that the incident in question altered the soft tissue or bony structures of [the Appellant]'s spine to [the] extent she would later develop what has been referred to as instability or cerebellar tonsillar ectopia.

[Sports medicine physician], the Appellant's own treating physician, was himself sceptical of the diagnosis of CCI, expressing the opinion that most radiologists would not give that diagnosis. He called CCI a "fad", likely to "fizzle out over time".

On the issue of CCI/CTE, the panel preferred the evidence provided by [sports medicine physician], and especially by [MPIC's HCS medical consultant], to that of [Appellant's consulting chiropractor] and [Appellant's treating chiropractor]. The panel finds that [MPIC's HCS medical consultant], in the preparation of his reports, had the opportunity to review all of the medical reports, assessments and reports of interventions on the Appellant's file and was thorough and comprehensive in his analysis. Although [Appellant's consulting chiropractor] noted that he had reviewed the documentary evidence in preparation for his testimony, we find that his report dated July 6, 2017, is not comprehensive in its analysis. It does not address any of the Appellant's prior history. [Appellant's

treating chiropractor] had not previously treated any patients with this condition, and he saw no problems with the Appellant's neck when he first treated her in 2007. We do not find his evidence on this issue to be persuasive.

Therefore, we find that the Appellant has not met the onus of establishing, on a balance of probabilities, that she suffers from a medical condition known as CCI or CTE that is causally connected to the MVA.

Conclusion

Accordingly, after a careful review of all of the documentary evidence filed in connection with this appeal, and after careful consideration of the testimony of the witnesses and of the submissions of counsel for the Appellant and counsel for MPIC, and taking into account the provisions of the relevant legislation, the panel finds that the Appellant has not met the onus of establishing, on a balance of probabilities, that her medical condition is causally connected to the MVA.

Disposition:

Consequently, the Appellant's appeal is dismissed and the Internal Review decision dated December 6, 2011, is therefore upheld.

Dated at Winnipeg this 14th day of July, 2021.

JACQUELINE FREEDMAN

BRIAN HUNT

SHARON MACDONALD