

**Automobile Injury Appeal Commission
Province of Saskatchewan**

Citation: *A.Y. v. Saskatchewan Government Insurance*,
2004 SKAIA 016
Date: 20040430
File: 048 of 2003

BETWEEN

A.Y., Applicant

and

Saskatchewan Government Insurance, Respondent

Appearances:
A.Y., Applicant
Darrell Mack, for the Respondent

Before: **Ann Phillips, Q.C., Chair**
Beverley Cleveland, Commission Member
Al Knippel, Commission Member

**THIS DECISION HAS BEEN EDITED TO PROTECT THE PERSONAL AND HEALTH
INFORMATION OF INDIVIDUALS BY REMOVING PERSONAL IDENTIFIERS AND
OTHER IDENTIFYING INFORMATION.**

Heard at Saskatoon, Saskatchewan
December 15, 2003

DECISION

[1] The Appellant, A.Y., appeals a decision of Saskatchewan Government Insurance (SGI) dated February 28, 2003 that denied responsibility for:

- (1) Low back pain radiating into the left leg and left hip problems.
- (2) Spinal stenosis involving his neck and lower back.
- (3) Brain or head injury.

[2] As a result, his income replacement benefit was terminated effective March 20, 2003.

[3] In addition, SGI denied reimbursement for customized orthotics and a temporary “heel spur cushion”.

FACTS

[4] The Appellant, an Alberta resident, was injured in a motor vehicle accident in [Saskatchewan location] on March 7, 1997. In the accident with him was E.O., a friend and co-worker. E.O.’s wife testified that he had been very quiet right after the accident, and was upset because he was unable to grip with his right hand. E.O. and his wife insisted that he see a doctor, and Dr. Syed of Saskatoon examined him March 8, 1997.

[5] Dr. Syed’s notes states:

“Pain lower cervical region {and} supra scapular region {and} interscapular region {and} pain {and} tingling in the hypothenar eminence {and} tips of fingers – medial 3 fingers.

C. Spine Pain turning left {and} rt (more rt) Movements c. spine painful {and} restricted.

Sid bending painful – Flexion {and} extension painful {and} restricted. Pain lower back – lumber {and} S.I. region. Left side – Movements back – painful {and} restricted. rotations, side bending, flexion {and} extension, Radiation of pain up to buttocks – Muscle spasm [???] –

Headaches off {and} on , No Nausea, No Vomiting, Pain occipital region –

A {Diagnosis} Cervical Myalgia, whiplash ??Radiculopathy”

Admit¹ St. Paul's Hospital Emergency for further investigation ???”

[6] Despite the recommendation, the Appellant did not go to St. Paul's. He returned home to [Alberta location] and then waited four days for a friend to drive him to Calgary, where he was seen by Dr. Graham Hunter. Dr. Hunter arranged for x-rays on March 14, 1997, which were reported as:

“LUMBOSACRAL SPINE WITH OBLIQUE AND SACROILIAC JOINTS

Slight narrowing of the L5-S1 disc space is noted posteriorly. Osteophyte spurring is seen through the lumbar spine anteriorly with no other selective disc space narrowing. The posterior elements show some minor degenerative hypertrophic changes mainly L5-S1. No acute bony injury is detected.

CERVICAL SPINE WITH OBLIQUES

Prominent osteophytes anteriorly accompany segmental discontinuous ossification of the anterior and longitudinal ligaments particularly at the C4-5 and C6-7 levels. C6-7 and C3-4 disc spaces are mildly narrowed with some posterior marginal osteophytes at these levels as well. Uncovertebral joint osteophyte at C3-4 on the right produces a moderate narrowing of the bony foramen and some lesser mild bilateral narrowing is seen from uncovertebral joint osteophyte at C6-7. No acute bony injury detected.”

[7] Dr. Hunter's initial report stated: “Acute pain occiput R shoulder, R arm, neck, L buttock pain, L sciatica. Head on collision other driver turned left in front of him. Evidence of prior injury or disease: None known.”

[8] In fact, the Appellant did have both the underlying degenerative condition of the lumbar and cervical spine described in the x-rays, and symptomatology in his right shoulder and left knee which predated the accident, as appears from clinical notes from May to July, 1995. He also had left hip pain and pain radiating down the back of his left leg which he reported in May, 1996 as having gone on for 9 to 12 months, and which continued to at least the end of 1996.

[9] After seeing Dr. Hunter, he began physiotherapy. By September 30, 1997, the physiotherapist reported that while his complaints in neck and low back had improved, he still had pain with mild radiation to the right C8-T1 area and the left buttock. He had limitation of movement in both the cervical and lumbar spine.

¹ Could be “Advise”.

[10] SGI appointed a rehabilitation consultant in Alberta to monitor the situation. The Appellant was still off work, with dizziness and blackouts. His job as a metal worker involved working on scaffolding. Ms. Briggs reported a meeting she had with Dr. Hunter, discussing the reduced range of motion in the right shoulder and diminished right hand grip, the degenerative changes of the lumbar spine shown on the CT scan, and pathology shown on an MRI of the cervical spine. He had referred his patient to Dr. Dewar, orthopaedic surgeon, for assessment in August, 1997.

[11] Dr. Dewar said, "I could not define a neurological level consistent with his symptomatology". However, he had obvious pathology on the MRI scan, most noticeably at C3-4 and C6-7, where there was foraminal narrowing and spurring implying interference with the root exit. Apart from limited range of motion, he had some weakness in the power muscles of the right shoulder, elbow and forearm with crepitus in the subacromial rotator cuff. Other findings were normal. While Dr. Dewar found no clear neurological lesion to explain the Appellant's symptoms, he said he was improving but that it was appropriate that he remain off work. He wished to carry out EMG nerve conduction studies and sensory evoked potentials to ascertain if there was a neurological lesion.

[12] On November 18-19, 1997, the Appellant was sent to Wascana Rehabilitation Centre in Regina for tertiary assessment. The diagnosis was:

"Injury Related:

1. Whiplash Associated Disorder III.
2. Low Back Grade II superimposed on pre-existing degenerative changes to the hips (right not confirmed by x-ray).
3. ? Post-Concussion Syndrome.

Non-Injury Related:

1. Osteoarthritis left hip.
2. Degenerative changes cervical and lumbar spine."

[13] By early December, 1997, he had been discharged from physiotherapy as he was not progressing: still complaining of soreness in cervical and lumbar area.

[14] He was referred to a pain management program at Columbia Rehabilitation Centre in Calgary in March, 1998. After two weeks, it was noted:

“[The Appellant] is not functioning within reasonable expectations. For example, he has not made any increases in functional activities in two weeks. As well he is unwilling to try increasing any components of his program...

[The Appellant] seems to find it a challenge to not focus on the pain and what he has lost in his life. This is making it difficult for him to fully participate in the program. The client’s negative self-talk is also a barrier in regards to progress as he verbally talks himself out of attempt to progress functionally before ever physically trying.”

[15] The Appellant was shown this report and said that he disagreed with it.

[16] This problem intensified, with the Appellant becoming increasingly negative and angry with the Columbia Rehabilitation personnel. A Wascana therapist in the discussion suggested the possibility of a mild closed head injury, which might explain his reluctance to comply and general attitude.

[17] The Appellant was therefore referred for neuropsychological evaluation by Dr. Timothy Landry, registered psychologist, on May 7-8, 1998. The testing showed impairment in five of 31 areas and in the below average to average range in the remaining 26 areas. Dr. Landry concluded that: “It is possible that he sustained a Grade I Concussion (Confusion, No Amnesia, No Loss of Consciousness) in the motor vehicle accident of 07 March 1997.” His subjective complaints were consistent with commonly reported post-concussion syndromes which were additional evidence that he may have sustained a Grade I concussion. He had impairments in specific areas of functioning which likely represented subtle decreased ability secondary to a possible Grade I concussion and a significant pain focus which affected his level of concentration and effort on tasks requiring abstract thought.

[18] He thought the Appellant needed counselling and education on chronic pain management, without which it would be difficult for him to return to work. If his pain complaints subsided or were better managed, the cognitive impairments would not likely prevent him from returning to his former occupation. A two year post-injury time frame should be used to measure his eventual level of recovery potential to benefit from rehabilitation.

[19] As a result, after a case conference, SGI decided that a combination of a program of pain management for chronic pain at Myosymmetries in Calgary, together with a vocational program in Edmonton, would best address his needs.

[20] At Myosymmetries, Dr. Donaldson, psychologist and clinic director, diagnosed myofascial pain syndrome and a closed head injury based on a “quantitative electroencephalograph” and proposed to treat him with trigger point massage therapy, electromyographic therapy, EEG neurotherapy, myofascial release and cranial sacral physiotherapy, twice weekly.

[21] In early January, 1999, Dr. Donaldson reported marked improvement in the Appellant’s brain wave patterns as a result of the therapy and improvement in his cognitive function.

[22] The Edmonton vocational program was discontinued before the Appellant could attend.

[23] Meanwhile, in December, 1998, SGI sent the Appellant for a Functional Capacity Evaluation at Deer Valley Physical Therapy in Calgary. The physiotherapist determined that he was capable of working within the light to low medium level, allowing frequent changes in posture and with heavier lifting to be done primarily with the left hand. She recommended range of motion and strengthening exercises daily as he was not performing those learned at Columbia Rehabilitation. She felt that he demonstrated inconsistent performance and demonstrated many pain behaviours. The Appellant complained about the physiotherapist and also complained about his pain and discomfort following the FCE.

[24] Della Robertson, a new vocational consultant at Kathryn S. Leonard & Associates Ltd., met with the Appellant on January 22, 1999, who discussed his current complaints: leg and arm pain, concentration, memory and speech. She met with Dr. Donaldson who said that his treatment had proceeded well but he had nerve root entrapment at C6-7. The Appellant was “very fixated on pain...he may have had a legitimate basis for this”. The EEG treatments for his brain injury produced considerable improvement; he would likely not require further treatment. He might require specialized physiotherapy for his neck and a neurosurgical consult.

[25] Dr. Hunter referred the Appellant to a physiatrist and Ms. Robertson met with Dr. Hunter on February 8, 1999. Dr. Hunter provided the EMG nerve conduction studies done in October, 1997, by Dr. Dewar, who noted that the areas of anatomy where he complained of pain symptoms did not form the territory of normal anatomical distribution of nerves to the upper extremities, and was therefore not a surgical candidate. Ms. Robertson provided Dr. Hunter with information that he had had a neuropsychological assessment, as well as the FCE done in December, 1998, and discussed his pain focused and disability focused behaviour. Dr. Hunter agreed that the Appellant could return to work at the light to medium category of work (presumably based on the FCE).

[26] On March 1, 1999, the Appellant was assessed by physiatrist Dr. Christine McGovern.

[27] Dr. McGovern had medical history information only from the Appellant himself. Her physical examination showed moderate restriction of cervical range of motion and mild to moderate restriction for lumbar range of motion. His leg length measurements were symmetric and his gait was unremarkable. Other tests were normal apart from a small palpable click at the left hip. She concluded:

“Although [the Appellant] has significant degenerative disease of the spine noted on X-ray, I do not feel that nerve root impingement is causing his ongoing discomfort. I believe his discomfort may be from the degenerative changes themselves along with superimposed pain of soft tissue origin and muscle spasm.”

[28] She thought he had a chronic pain condition of mixed etiology, with anxiety likely contributing to the problem. She thought he should have a neuropsychologic assessment to assess his cognition and stress levels, and queried whether psychological counselling would be appropriate. She questioned but thought unlikely that the “bright feeling” he experienced in his forehead could be basilar artery insufficiency with occipital cortex ischemia.

[29] When the Appellant saw the report, he telephoned Dr. McGovern to correct a number of inaccuracies.² She maintained her position with respect to leg length symmetry.

² Additional symptoms were recorded; information on medication was provided; he disputed her findings of symmetric leg length with additional data.

[30] On Dr. McGovern's recommendation, Dr. Stewart Longman, psychologist, did a second neuropsychological assessment dated May 26, 1999. His overall functioning was in the average range. Attentional skills for visual and spatial material were average, but below average to borderline for auditory material. He had mild difficulty on memory functioning, average executive functioning, some right hand weakness and mildly impaired dexterity. Dr. Longman thought that he was experiencing some interference with attention and memory due to reduced self-confidence and interference due to pain. He was anxious because of apparent contradictions in medical diagnoses and recommendations. Dr. Longman suggested that successfully treating his pain and disability would lead to marked decreases in attention and memory difficulties. He suggested a medical case manager to organize and integrate the medical information and clear up apparent contradictions.

[31] The Appellant was referred to the FIT for Active Living program at Saskatoon City Hospital for an initial assessment in October, 1999. They felt that medically he was healthy except for osteoarthritis. There were no neurological findings. The cognitive complaints he described were likely related to pain. He exhibited a number of pain behaviours and symptoms of moderate depression and sleep difficulty. He had not responded well to active rehabilitation.

"Primary Diagnosis (related to the motor vehicle accident of March 7, 1997):

1. Chronic pain syndrome; unable to diagnose with WAD or LBP due to inconsistencies and pain behaviours

Secondary Diagnoses (not related to the motor vehicle accident):

1. Osteoarthritis of hips, right elbow, right and left AC joint shoulder
2. Smoker"

[32] His prognosis was considered "very poor" and no further treatment was recommended, since his symptoms had not improved over the last 2½ years. The treatment team felt that he had reached his maximum recovery, with no further treatment expected to improve his physical status.

[33] On December 28 and 29, 1999, he was sent for a Functional Capacity Evaluation at Canadian Back Institute in Calgary. It concluded he was capable of performing a light level occupation, and noted inconsistencies throughout testing and pain focused behaviour. They did not recommend further treatment.

[34] He had a third neuropsychological assessment by Dr. Valorie Selland on January 31 and February 7, 2000. She noted “very pain focused behaviour” that she thought interfered with his performance and especially attention and concentration. She thought his cognitive functioning had declined since the accident “with some indication that his pre-trauma skills were at least within the average range”.

[35] She stated:

“However, it is felt his difficulties in neuropsychological functioning do not reflect solely the effects of a concussion he may have sustained as a result of this accident. It is likely that the overall mild difficulties [the Appellant] is experiencing are attributable to several consequences he may be experiencing as a result of this collision. First of all, based on information which was provided, it does appear possible that [the Appellant] sustained a concussion as a result of this collision. By way of review, symptoms which are often associated with a postconcussional syndrome include a large number of diverse symptoms including headache, dizziness or feelings of light headness and instability, tinnitus, deafness, irritability and difficulty in controlling feelings of anger or sadness, difficulty with sleeping, fatigue, impairment of memory, short attention span, and episodes of depression and of uncontrolled rage... [the Appellant] certainly reported many of these symptoms, including blurred vision, dizziness, ringing in the ears, headaches, sleep disturbance, attention and memory changes, and changes in emotional functioning and behaviour following this collision.

While it does appear possible that [the Appellant] sustained a concussion following the collision, research suggests the majority of individuals who sustain a concussion or mild brain injury are generally symptom free particularly by one year post-trauma. [The Appellant] is now almost three years post-trauma, and continues to reportedly experience these difficulties. While these difficulties may reflect the continuing effects of a concussion, it is important to note that there are other factors that may also be contributing to his current presentation. For example, as a result of this collision, [the Appellant] continues to report experiencing a significant level of pain and discomfort, and he has been diagnosed with a chronic pain syndrome. It is important to note that pain symptoms may also affect attention, concentration and memory... [The Appellant] is experiencing a clinically significant level of psychological distress related to the disabilities he has experienced since the collision. This includes symptoms of depression and anxiety. It is important to note that these symptoms may also have an impact on an individual’s cognitive functioning, including attention, concentration, and memory functioning... Therefore, it is felt more likely that other issues, particularly including a chronic pain syndrome and a clinically significant level of psychological distress, are contributing to [the Appellant]’s current deficits in neuropsychological functioning, rather than representing the continuing effects of a possible concussion.”

[36] She observed that there appears to have been a decline in his memory functioning compared to Dr. Landry’s assessment in May, 1998, from mild to moderate in some areas. In view of this apparent decline, she thought it more likely that chronic pain issues and psychological distress were contributing to his current impairment. The decline in memory and mental and physical functioning is not a typically expected finding following a concussion or

mild brain injury. If the chronic pain issues, pain focused behaviour and psychological distress could be resolved to some degree, she thought it likely he would be able to retrain in new skills. She identified his anger and irritability, and recommended a referral for psychiatric evaluation.

[37] Dr. Singh, psychiatrist, saw the Appellant on June 2, 2000. The second sentence of his report reads: “[The Appellant] is a [age] gentleman who had an unfortunate automobile accident resulting in severe head injury.” He diagnosed underlying symptoms of depression and significant neurological problems (word finding problems, difficulty reading and writing, constant flashes of light which appeared to be coming from inside his head). Dr. Singh recommended neuropsychological testing “in terms of finding what areas of his brain are still functioning”. He also recommended therapy for post-traumatic stress disorder.

[38] In July, 2000, a Transferable Skills Analysis was carried out by NRCS. It failed to identify any suitable occupation either because of the physical activities requirements (body position, strength) or employment requirements (no trade certification, education).

[39] Nothing much happened for a year and a half.

[40] In December, 2001, he was seen by Dr. Jason Werle, orthopaedic surgeon. The Appellant described the accident to him. Dr. Werle reported:

“He apparently developed some significant head trauma and injuries to both hips, the left side was worse than the right. He has had a cognitive impairment with memory loss since this. Apparently he sustained an injury to the left hip, which required no surgery. Apparently there was a slight fracture/dislocation according to his reports.”³

[41] Dr. Werle stated: “Radiographs were available for review.⁴ They reveal post traumatic osteoarthritis of both hips. The left side appears worse than the right.”⁵ Dr. Werle prescribed Vioxx and at least contemplated the possibility of total hip replacement. When Dr. Werle saw

³ As can be seen, this description of the accident is completely inaccurate with respect to the hips, and probably with respect to the head injury.

⁴ Which ones were not specified, but likely the ones done December 12, 2001. It is unlikely to refer to the left hip x-ray done immediately after the MVA: Joint space narrowing and osteophyte lipping accompanies subchondral sclerosis and cyst formation with moderate osteoarthritic degenerative changes in this hip.

⁵ The diagnosis of “post-traumatic” osteoarthritis is suspect because of the inaccurate history.

him again in February, 2002, he suggested a referral to a spine specialist for his lower back, which was then causing more problems than the hips.

[42] In early April, 2002, Della Robertson met with Dr. Puts, now the Appellant's family physician, and with the physiotherapist. The latter had seen the Appellant mountain biking frequently around town and on the highway. The doctor, who had seen him painting a big fence around a trailer court the previous summer, cleared him for a return to work by the end of April. She attempted to obtain pre-accident medical information. Dr. Puts then felt he should wait to sign the return to work authorization until updated information had been obtained from the Community Geographic Head Injury Team from Alberta Mental Health. Bev Webster, social worker, discussed his case with Della Robertson. She referred to his non-use of prescribed medication (antidepressants, Vioxx), possible mental health issues (paranoia) and yet another change of physicians.

[43] At the end of April, Bev Webster helped him complete CPP disability forms.

[44] An MRI of the cervical spine was done in June, 2002:

“Multilevel degenerative disc change throughout the cervical spine, most pronounced with a small central disc herniation and small posterior osteophyte at the C4-5 level with mild focal spinal canal stenosis resulting in narrowing of the thecal sac, which measures 1.0 cm AP. Small central disc herniation as well, at the C2-3 level resulting in minor focal spinal canal stenosis without significant spinal cord encroachment. The AP dimension of the canal at this level measures 1.2 cm.

Other degenerative change is less significant. There are right uncovertebral joint degenerative spurs at the C3-4 level resulting in possibly significant lateral neural foraminal encroachment and encroachment upon the exiting right C4 nerve root.”

[45] In August, 2002, Della Robertson met with Dr. Hoeve, the Appellant's new family physician. Dr. Hoeve also speculated that the Appellant's difficulties in understanding might be the result of a brain injury. He did not think, as suggested by Bev Webster, that having him volunteer or return to work was a reasonable option from the perspective of his current medical status. He had referred him to an orthopaedic surgeon in Red Deer specializing in back pain. Ms. Robertson provided context in the investigations that had previously been carried out.

[46] Bev Webster's report was forwarded October 15, 2002. She diagnosed "Persistent Post-Concussive Syndrome" as one of the approximately 10% of persons who have experienced a mild traumatic brain injury and continue to experience symptoms 12 months post injury. She thought he should have emotional adjustment counselling.

[47] Her report was considered in a November 4, 2002 report by Dr. Shaun Gray, also of the Alberta Mental Health Board.

[48] Dr. Gray's careful seven page report summarized an examination by a psychiatrist, physical therapist, occupational therapist and communication therapist, who were asked to assess the Appellant's readiness for return to some form of productive activity, and in particular, whether he had reading and writing skills to enable him to take training courses and/or the physical and mental stamina to participate in the courses. Dr. Gray referred to the Appellant's complaints of chronic diffuse pain, and difficulties with thinking and memory skills. He had some earlier medical reports to refer to.⁶ His reports of numbness, neck cracking and ringing and whistling noises in his ears were investigated. The noises he heard were not audible, and the numbness was not associated with anything but mild weakness. He did have mild leg length discrepancy of 1.2 cms., decreased internal rotation of the hips, decreased abduction range at the right shoulder, a sitting tolerance of about 15 minutes, limited range of motion of the cervical spine in all directions. The physical therapist also had difficulty in obtaining a reliable and consistent examination. The speech language pathologist noted slow auditory processing, problems of verbal expression in generating answers to questions in sentences, and severe impairment in multitasking. He had poor work force literacy skills in reading and writing, to the extent that it was concluded he would not be able to independently successfully participate in vocational retraining based on his communication and language dysfunctions.

[49] Dr. Gray concluded:

"Summary and Recommendations:

This [age] man is now approximately five years following what may have been a mild traumatic brain injury with post concussive symptomatology. He has persisting complaints of cognitive dysfunction, psychological distress, and persisting chronic pain with associated physical dysfunction. Overall, the abilities displayed on today's visit would seem to represent significant

⁶ CT scan, December, 2000; x-rays of pelvis, left hip and C spine from January, 2000 and September, 2001.

adverse change from multiple neuropsychological assessments suggesting relatively mild neuropsychological impairment. He does have radiographic evidence of significant bony pathology including degenerative arthritis in both hips, and significant osteophytosis and degenerative change in his cervical spine. It is certainly feasible that some of his complaints of numbness, tingling, snapping, and cracking are related to his axial skeletal pathology. He reports that he has not found much relief with any medications to date and reports that he has developed adverse reactions to most medications that have been tried. He has not received any benefit from previous rehabilitation programs. He remains in some dispute with an insurance company.

Today's Outpatient Clinic was largely unsatisfactory in delineating a clear etiology for [the Appellant]'s current complaints. On reviewing the referral information provided to us, it would seem that [the Appellant] had deteriorated in his overall level of functioning and cognitive skills. I would suspect that this is unlikely to be directly related to the presumptive mild neurologic injuries sustained in the motor vehicle collision of 1997. His previous neuropsychological assessments have suggested a large component of psychological distress and he certainly has difficulties with ongoing chronic pain that may also be contributing to some of his subjective cognitive concerns. He does have significant radiographic findings of skeletal pathology including diffuse osteophytosis and degenerative arthritis."

[50] Dr. Gray recommended compensatory strategy for his cognitive complaints (daytimer, pocket recorder, pocket notebook), ongoing psychological counselling (although he "did not seem overly psychologically minded and the prognosis of benefit from this approach would be somewhat guarded"), and medication directed more specifically at his chronic pain. Other recommendations included a possible referral to home care for assessment for support for independent living and a rheumatology referral for the "somewhat unusual degree of degenerative change in his skeleton". He did not think that further static imaging of his brain would be of any benefit and concluded that they had relatively little to offer him at the Brain Injury Rehabilitation Program:

"Based on our assessment today, his past recent history as outlined in the referral information and his radiographic findings, the prognosis for any meaningful return to work or vocational retraining would seem to be extremely limited."

Dr. Alport's Evidence

[51] Dr. John Alport testified by telephone. He graduated from the University of Saskatchewan in medicine in 1978 and has worked in the fields of family medicine and emergency for 20 years. He then took courses in occupational medicine, focusing on independent medical examinations and disability evaluations. He has been a consultant to SGI for five years and its Medical Director for eight months. He provides a "file review" of the claimant's entire chart, or as much of it as can be obtained, in order to clarify medical issues for

SGI or to answer specific questions for them, such as whether the symptoms are consistent with the accident.

[52] He believes that the Appellant's initial application to SGI for benefits and the first few practitioner's reports received by SGI are extremely important. He then does a chronological review of the medical information, and notes that sometimes information is missing and that the questions asked of him cannot be answered. He observed that there are frequently conflicting medical opinions, often because these are based on information obtained from the Appellant by the practitioner, who may not have the benefit of the full medical history that Dr. Alport attempts to obtain. He acknowledged that a common complaint is "How can a person evaluate me if he has not even seen me?" His answer to this is that he is quite conscious that he is just doing a file review and looking at the information available. He always qualifies his opinions to this effect. Medical consultants to the insurance industry generally follow this practice. He acknowledged that the information available to him is not always "good". He does have the option of contacting the physician directly, or of contacting and referring to consultants. He considers practitioners other than physicians and surgeons: he believes that physiotherapists can often provide a better view when they have seen a person daily over a course of 12 weeks, as occurs in secondary or tertiary treatment.

[53] Dr. Alport's involvement in this file dates from December, 2001 as follows:

December 31, 2001
November 10, 2002
February 13, 2003
April 16, 2003
September 15, 2003 – this document" was filed at
the hearing

[54] Dr. Alport's initial assessment noted the following:

- (1) There were no details of the motor vehicle accident of March 7, 1997 available other than the fact that his 1989 vehicle was totalled, and that he had not sought medical care the day of the accident.

- (2) He found Dr. Hunter's clinical notes useful, but observed that Dr. Hunter had never treated the Appellant before the accident, and like other doctors after him, had accepted the Appellant's statement that he was absolutely fine until that time.
- (3) The rehabilitation consultants initially had not suggested that pre-existing medical records be obtained, which he considered a big deficiency.
- (4) He endorsed the recommendations made by Garry Derenoski of Innovative Rehabilitation Consultants (IRC) of April 24, 2001, outlining deficiencies in the documentation and recommendations for remedying them.
- (5) He agreed with Dr. Glenn Pancyr, psychologist, that no further psychological interventions were required. He added: "I do not believe that [the Appellant] has a significant head injury. If he did sustain any impact to the brain, the effects have long since recovered."
- (6) He thought that the Appellant's chart was "full of evidence of inconstancies (sic)", and noted the opinion even from his own physician⁷ that he can work at a medium level job. He suggested that although he might have difficulty working at heights and on scaffolding, metal workers could work on level ground or in the shop, in his experience, and recommended that this be followed up with former employers.
- (7) He agreed with the physiatrist⁸ that the hip pathology was unrelated to the motor vehicle accident. He added: "in all likelihood the neck arthritic problems are not significantly related to the accident". It was his view that the MRI, which he said was "nasty looking", appeared to him to be "long standing arthritic changes with disc bulges and spinal stenotic lesions". He thought these would have looked the same if the MRI had been done just before the accident. The same applied for the

⁷ Dr. Hunter, in February, 1999: "light to medium".

⁸ She actually says: "Although [the Appellant] has significant degenerative disease of the spine noted on X-ray, I do not feel that nerve root impingement is causing his ongoing discomfort. I believe his discomfort may be from the degenerative changes themselves along with superimposed pain of soft tissue origin and muscle spasm."

x-rays of his hip and for the low back, which showed what he thought were pre-existing osteoarthritic changes and degenerative processes.

[55] After some, if not all, of the information he sought was obtained, Dr. Alport reviewed the file again in November, 2002. The additional medical information included the initial practitioner's report,⁹ Dr. Dewar's report of August 19, 1997, the Functional Capacity Evaluation done December 28-29, 1999, Dr. Singh's report, and the Bev Webster report of October, 2002.

[56] His further conclusions were as follows:

- (1) Dr. Ballantine's pre-accident medical reports showed that he had significant left hip pain at least two years before the accident, and a prolonged right shoulder injury. They did not show significant pre-existing neck problems, but the MRI and lumbar spine studies done post-accident showed "at least significant degenerative changes from a radiological standpoint" which might be contributing to his current symptoms.
- (2) Dr. Dewar's 1997 report showed normal EMG studies, no neurological lesions and an underlying multisegmental degenerative cervical spine. As a result, Dr. Alport considered that the Appellant's current symptoms were secondary to a pre-existing medical condition. Moreover, it was not his neck which was the primary disabling condition, and as far as he could tell, was not what was keeping him from work. It was spinal stenosis involving both his neck and lower back, a degenerative condition (which would likely deteriorate and require surgery) that was causing problems. It was unrelated to the MVA.
- (3) His lower back pain radiating into the left leg was probably related to his pre-existing arthritic hip. Although the orthopaedic surgeon had diagnosed this as "*post-traumatic* bilateral osteoarthritis of the hips", he doubted this since there was no evidence of significant injury to the hip at the time of the accident, and certainly not bilateral injuries. Also, while the radiological evidence showed a

⁹ Dr. Hunter, March 15, 1997.

degenerative low back condition, there was no suggestion that there was a significant low back injury that would cause permanent problems.

- (4) He concluded that there was no objective evidence of head injury. If there was a brain injury at all, it was minor and would have resolved long ago. All of the possible “head injury symptoms” appeared in the medical record many months after the injury, and most became worse not better. This is contrary to the accepted understanding that symptoms become better over time, not worse.
- (5) He described the report of the consultant psychiatrist in Red Deer as “not credible”, as based on the premise that the Appellant had sustained a severe head injury. Since this assumption was inaccurate, the rest of the consult could not be considered believable.
- (6) Bev Webster’s assessment, he thought, was based on the assumption that the Appellant had been hospitalized in Saskatchewan following the accident, which was not the case.¹⁰ The unusual symptoms of hearing and comprehension problems, vision blurring, dizziness and balance difficulties were medically unexplainable in terms of the accident, since they were not present for many months following the accident, but were present five years later.
- (7) He did not think the Appellant could return to his pre-accident employment because of osteoarthritis of the hips (pre-existing) and progressive degenerative disease of the neck and spine, which would preclude heavy work. His pre-accident job records made it difficult to ascertain what his job tasks were.
- (8) “It seems clear from all of the medical, and some non-medical information, that he will not return to his former occupation, he will be non-compliant with medical treatment, and he will continue to pursue his claim.”
- (9) He rejected reimbursement for customized orthotics because of measured leg length differences. These would be pre-existing and likely congenital. If they were due to the chronic back problems (which were pre-existing), he said that

there was poor evidence that orthotics were useful for long term management of these.

[57] As Dr. Alport said that he would value Dr. Pancyr's opinion, SGI arranged for this to be done. Dr. Pancyr's report of November 29, 2002 stated, in part:

"It was further noted in this assessment (Dr. Landry's neuropsychological assessment in March, 2000) that the customer's mental and physical functioning were deteriorating even three years post-MVA. Such mental deterioration is not consistent with the effects of a concussion, especially a mild one, but such deterioration is consistent with the effects of persistent pain, and psychological distress, which according to Dr. Alport were largely pre-existing the MVA.¹¹

Dr. Alport's November 10, 2002 medical opinion regarding the customer's reported symptoms of neuropsychological dysfunction is that the customer does not have a brain injury and that it is questionable whether his complaints of cognitive dysfunction can be attributed to the effects of a concussion. The critical observation being that the cognitive symptoms did not appear immediately following the MVA but only developed several months following the MVA.

Opinion:

In brief, I concur with Dr. Alport's conclusions regarding the psychological and neuropsychological aspects of this case. I find, after a review of the documents provided that my original opinion remains unchanged. Rather than facilitate recovery, I believe the proposed treatment plan of Ms. Webster's may serve to entrench the customer's perception that he is brain injured. If this anticipated effect occurs then the treatment proposed may serve as an iatrogenic factor that will perpetuate and maintain his current level of perceived disability. I do not support the recommendations as outlined in Ms. Webster's report."

[58] Following receipt of the two reports of Dr. Alport and Dr. Pancyr, SGI issued the decision letter of February 28, 2003 that is the subject of this appeal.

[59] In 2003, the Appellant provided a chart note from Dr. Syed in Saskatoon, who saw the Appellant the day after the accident, discussed above at paragraph [5] and [6].

[60] Dr. Alport concluded from this report that there was nothing in it which would change his previous opinions. It confirmed that there was no significant head injury. While Dr. Syed had thought there might be radiculopathy, subsequent information had ruled out that possibility.

[61] In September, 2003, Dr. Alport reviewed three new medical reports:

¹⁰ This may be an over-emphasis on the influence of one inaccuracy in the report.

¹¹ We do not interpret Dr. Alport's November, 2002 report as indicating that the Appellant experienced psychological distress before the MVA. Pain, yes; "persistent pain", no.

- (1) Dr. Shaun Gray, Physical Medicine and Rehabilitation, Outpatient Brain Injury Clinic, Alberta Mental Health Board, of November 4, 2002;
- (2) Dr. Jacques Bouchard, Orthopaedic Surgeon, University of Calgary Spine Program, of March 20, 2003;
- (3) Dr. Jason Werle, Orthopaedic Surgeon, of April 1, 2003.

[62] Dr. Alport's comment was that Dr. Gray's final paragraph on page 5¹² seems "to correlate best with my own opinion and that of Dr. Glenn Pancyr's. None of us believe this gentleman sustained a brain injury of such severity that any of his current problems are related to the motor vehicle collision of 1997."

[63] The orthopaedic (spinal) surgeon's report of March 20, 2003 referred to poor range of motion in the neck, an unsteady gait, some decreased muscle strength, reflexes and sensation. He described "quite extensive facet arthrosis", degenerative disc disease, calcifications of the longitudinal ligament. The MRI showed significant stenosis at C3-4, C4-5, C5-6 and C6-7, with some flattening of the spinal cord at C3-4 and C4-5. His impression was:

- “1. Whiplash associated disorder with all of the associated symptoms of tinnitus, dizziness, headaches.
2. Cervical spinal stenosis diffuse.
3. Diffuse idiopathic skeletal hyperostosis and facet arthrosis.
4. Hip osteoarthritis.

Suggested Plan:

1. Whiplash associated disorder: No treatment is effective for this. He will have chronic disabling neck pain for the rest of his life.
2. Cervical stenosis: This certainly could be causing the majority of his arm symptoms and numbness and weakness and this could be improved upon with surgical decompression. He is also at risk if he does have a hyperextension injury for cord deficit such as a central cord syndrome.
3. No specific treatment for DISH.
4. Hip osteoarthritis: I understand that he has been referred to Dr. Werle to address this problem. In the event that he does have hip surgery, the anesthetist will have to be careful about intubating him unless his spinal stenosis is treated first.”

[64] Dr. Bouchard had put him on the waiting list for a posterior laminoplasty multiple levels and fusion, while noting that this would not improve his neck pain.

¹² Quoted above at paragraph [49].

[65] Dr. Alport commented:

“P.S. I reviewed the ‘summary’¹³ of the spinal surgeon which includes several diagnoses. The way it’s written it appears that this gentleman’s ‘chronic disabling neck pain’ is secondary to the whiplash injury and that the surgery is being performed strictly for numbness and weakness. He also indicates there is no treatment for whiplash associated disorder. This appears to be a very definitive opinion provided by this Surgeon – and if I understand the report it suggests he will continue to have the severe disabling pain even after the surgery, and it’s all collision related. This case is very much more complicated than this suggests and the comment cannot be interpreted in isolation. I hope the report I have provided is clear – I’ve indicated that the accident may have contributed to some of his pain. It is unreasonable to suggest all his pain is related to the motor vehicle accident and that the cervical stenosis is only causing neurologic symptoms of numbness and/or weakness.

It is also quite likely that this gentleman should expect significant symptomatic improvement following surgery, and I am concerned that the surgeon appears to have predicted no improvement in pain – a comment I think that is disabling by itself and which I foresee as problematic for adjudication in the future. I’m not sure there is much that we can do about the comments made, but I thought I should point out my concerns at this time.”

[66] The other orthopaedic surgeon, Dr. Werle, advised the Appellant’s family physician on April 1, 2003 about the bilateral hip pain. After reviewing the x-rays, he recommended “a left total hip replacement” after his cervical spine was stabilized.

[67] Dr. Alport commented: “There is no evidence that he had a significant left hip injury at the time of the accident. I think the arthritic hip is a co-incidental medical illness unrelated to the motor vehicle accident.”

[68] There is convincing evidence in support of Dr. Alport’s conclusion that the hip problem was pre-existing. It is mentioned in physician’s notes of May 29, 1995,¹⁴ May 17, 1996,¹⁵ December 31, 1996¹⁶ and April 10, 1997 (one month post-accident).¹⁷

¹³ Actually the “suggested plan”.

¹⁴ “C/O Lower back pain radiating down L leg. Rx refilled. Reg. Dr. is Dr. Hunter. He has hip a CAT/MRI Scan. Seen in physio. Pain is over L leg and radiating down the thigh.”

¹⁵ “C/O Lt hip pain ongoing 9-12 mos... when he walks or bends over, he gets pain in his left buttock radiating down the back of his leg. OE he has good ROM of his back. Straight leg raises are 90. I think there’s probably some sciatic nerve irritation. I sugg’ed Naprosyn and he’ll see a chiropractor.”

¹⁶ “Rx refill Naprosyn. Has had hip and backpain. This has been an ongoing prob for him. He takes Naprosyn and actually does quite well with this. I have refilled his Naprosyn 375 x 45 as 30 has lasted almost a year.”

¹⁷ x-ray left hip: “Joint space narrowing and osteophyte lipping accompanies subchondrial scleriosis and cyst formation with moderate osteoarthritic degenerative changes in this hip.”

[69] With respect to the brain or head injury, after a consideration of all the reports by the neuropsychologists, psychologists, psychiatrist, physicians and social worker, we are in agreement with the conclusion that while the Appellant might have had a mild concussion in the motor vehicle accident, any difficulties he now experiences are attributable to psychological distress, likely associated with his pain and preoccupation with pain.

[70] With respect to the spinal stenosis of his neck and lower back, we note that there does not appear to be any reflection in SGI's decision of Dr. Alport's thoughtful attempt to apportion the contribution of the motor vehicle accident to the degenerative condition of his spine. As Dr. Alport states: "There isn't good evidence that he had disabling neck pain prior to the accident."

[71] Dr. Alport's opinion was given well after SGI's decision letter of February 28, 2003, and we acknowledge that this decision letter was fairly based on the information SGI then had available to it, and particularly Dr. Alport's letter of November 20, 2002.

[72] We were invited to and we believe that the Commission can and should look at the subsequent medical information in arriving at our decision. Dr. Alport states:

"The third item is the question of the proposed neck surgery. I actually predicted that he would go onto neck surgery for his degenerative condition in the report I dictated in November 2002. There is no doubt the general cervical degenerative condition is unrelated to the motor vehicle collision. It is symmetrical, multi-level, and is also associated with his other skeletal arthritic processes. The question that needs to be answered is whether the motor vehicle collision contributed to the degenerative process, or somehow 'accelerated' the natural course of this disease. I reviewed the other medical files and he did have right shoulder symptoms for some time back in 1995. He also had some chronic low back problems and some hip problems that are well documented and are pre-existing. *There isn't good evidence that he had disabling neck pain prior to the accident.* (emphasis added)

Following the accident he did complain of neck pain in addition to right arm pain. It is difficult to be certain whether this right arm pain is the same as the pain he complained of back in 1995. It is possible, but not certain. It is difficult to determine the severity of symptoms and the direct relationship between the motor vehicle collision and his current problems. This is partly due to the fact that he is a very difficult historian and has provided a number of different histories to different consultants over the years. I have no doubt that the proposed surgery was pre-destined to occur, even had no collision occurred. It is very difficult to 'apportion' the contributing percentage the accident had to the natural course of this disease. *If forced to provide an opinion, I would estimate that the accident contributed no more than 25% to the natural course of this disease.* (emphasis added) If I were to word it another way, I might suggest the accident accelerated the natural course of this disease and he is now having surgery performed that might not have been done for another 2 years were it not for the accident. These estimates are based on nothing more than my experience and a careful review of the entire medical file. I am sorry I can't be more definite. I hope this report is clear."

[73] In February, 2003, Dr. Alport advised that the Appellant was not entitled to a permanent impairment benefit for concussion, because of Dr. Pancyr's report of November 29, 2002.

[74] Our problem is how to apply his apportionment (25%) or acceleration of the surgery by two years to determine how it affects the Appellant's income replacement benefit. One way is to propose that payment of the income replacement benefit should be extended by two years from the date of termination on March 28, 2003, or extended for a period of two years from the date that he actually has the spinal surgery. Another is to order payment of 25% of the income replacement benefit.

[75] Following the hearing, each party filed an additional letter: The Appellant from Dr. Bouchard and SGI from Dr. Alport, as follows:

Dr. Bouchard

"This is to confirm with you that [the Appellant]'s symptoms of neck pain radiating to his shoulders is a direct result of a motor vehicle accident that he sustained in 1997 and is not related to his cervical stenosis. His range of motion restriction is a combination of the injury that he sustained in 1997 as well as arthritis called DISH (diffuse idiopathic skeletal hyperostosis)."

[76] Dr. Alport's reply noted that Dr. Bouchard's letter did not indicate any need for investigation or treatment, and so did not affect the management of the case. He further pointed out that as an opinion on "causation", he doubted if Dr. Bouchard had all of the available information upon which to base his opinion. He stated (and we agree) that the issue of causation requires information about the accident, initial symptoms, pre-existing problems, the history of symptoms since the accident, etc. He noted that there had been a problem in obtaining an accurate history from the Appellant.

[77] From the Commission's viewpoint, Dr. Alport's opinion as set out in paragraph [72] is consistent with Dr. Bouchard's short note. The only difference is that he does consider the "acceleration" factor, and Dr. Bouchard does not provide his thoughts on this issue. We do not know what he might say if this question were posed to him, and if he had the pre-motor vehicle accident information that was available to Dr. Alport.

[78] With some hesitation then, and with the greatest respect for Dr. Bouchard's position as Chair of the University of Calgary's Spine Surgery Program, we accept Dr. Alport's opinion on causation as set out in paragraph [72].

[79] We accordingly order that payment of the Appellant's income replacement benefits be extended from the date of termination on March 28, 2003 for a period of two years. We think this solution is preferable to one that extends payment of the income replacement benefit two years from the date of surgery, both because of the uncertain timing in view of surgical waiting lists and what we presume to be the Appellant's more immediate need for the money.

[80] While we considered ordering payment of 25% of the income replacement benefit, we believe that this is an unsatisfactory solution in that it leaves a claimant who is unable to work in straitened financial circumstances. In the Appellant's case we are aware that he is receiving CPP disability benefits, so it might not be as great a hardship for him as it would be for other Appellants.

Costs

[81] The Appellant is entitled to his costs including reasonable travel and meal expenses incurred in attending the appeal, the application fee, and the expenses of obtaining medical reports for the purpose of this hearing (and post-hearing) to the maximum amount of \$2,500 set out in section 96(1) of *The Personal Injury Benefits Regulations* in force on January 10, 2003.

Dated at Regina, Saskatchewan, on April 30, 2004.

Ann Phillips, Q.C., Chair

Beverley Cleveland, Commission Member

Al Knippel, Commission Member