

Automobile Injury Appeal Commission

Province of Saskatchewan

Citation: *A.H. v. Saskatchewan Government Insurance,*
2004 SKAIA 022

Date: 20040614

File: 079 of 2003

BETWEEN

A.H., Applicant

and

Saskatchewan Government Insurance, Respondent

Appearances:

A.H., 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
January 20, 2004

DECISION

[1] The Appellant, A.H., appeals a decision of Saskatchewan Government Insurance (“SGI”) dated May 5, 2003 terminating her income replacement benefits as of May 9, 2003.

[2] The decision stated that she was now substantially able to perform the essential duties of the employments she had at the time of the accident, based on a form completed by her general practitioner, Dr. Wall on September 7, 2001 and a Discharge Report from the rehabilitation team at FIT for Active Living dated April 29, 2003.

[3] SGI agreed from the start that the 2001 report from Dr. Wall was outdated, and should not be considered as a basis for its decision. As for the FIT report, it did not actually state that she was able to perform the essential duties of her employment. It stated:

“Prognosis

Client did not demonstrate ability to benefit from active treatment in four week trial at FIT. Prognosis is limited by pre-accident conditions – osteoarthritis of wrists and knees, including left knee replacement, prior to MVA. Conditions directly related to MVA are not major barriers to resuming former function.”

FACTS

[4] When the Appellant was injured in a motor vehicle accident in June, 2001, she had a number of pre-existing conditions, including osteoarthritis of both knees, degenerative changes in the cervical spine, fibromyalgia, irritable bowel syndrome, and other medical problems not germane to this inquiry.

[5] Her knees had been injured in a 1993 accident when she was crushed between two vehicles.

[6] Her cervical spine had been x-rayed in March, 1998, with the following report:

“CERVICAL SPINE

There is straightening of the curve. C4 is 3 mm forward on C5. The facet joints do not appear to align the C3-4 and C4-5 levels leading to suspicion of possible dislocation. There is no obvious fracture. Oblique views of the spine centered at C4 are recommended for further assessment of the facet joints to exclude fracture/dislocation.”

[7] Following the MVA in June, 2001, similar abnormal x-ray findings were observed. There was concern that she might have a fracture or dislocation of the cervical spine. Fortunately, this was not the case. The radiologist's report stated that the "ventral slip of C4 on C5" was related to ligamentous laxity or degenerative change, but since the facets and spinous process do not open "I find it difficult to believe that there has been significant soft tissue disruption at this level. If there is clinical pain and tenderness this must be considered to be a significant injury but if the area is pain and tenderness free there will be less concern for possible injury." The neurosurgeon reported:

"Her cervical spine dynamic x-ray reveals about 3 mm reduceable subluxation, anterior subluxation of C4 on C5 region.

...this could very well be due to underlying degenerative cervical spondylosis. However, I will review her x-ray from today with our Radiologist... if her follow-up x-ray reveals no fracture, I think she could be managed with discontinuation of her collar and physiotherapy at that point."

[8] The later (July) x-rays indicated:

"Marked degenerative changes about the C4-5 facet joint with no evidence of acute fracture, dislocation, or locked facet."

[9] The injuries she incurred in the 2001 motor vehicle accident, in addition to neck pain, were outlined in the emergency room report as left shoulder pain, left thumb pain, right tib/fib pain.¹ X-rays were carried out in these areas with the following results:

CERVICAL SPINE

No acute bone or soft tissue abnormalities detected.

LEFT SHOULDER

No abnormalities

RIGHT TIB FIB

Moderate degenerative changes are seen affecting the medial compartment of the knee and the patellofemoral compartment. No bone or soft tissue injuries detected.

LEFT THUMB

There are degenerative changes affecting the trapezium first metacarpal joint. No fractures or dislocations."

¹ She also had a sore wrist. In addition, she had severe epigastric pain four hours after the accident, which resolved spontaneously.

[10] Before her MVA, despite the pre-existing conditions referred to in paragraphs [4] to [6], the Appellant held part time jobs as a special care aide with [employer] and as a funeral attendant, and it appears that her employers were well satisfied with her work.

[11] The Appellant's husband and son gave evidence on the impact of the accident on her. She had enjoyed skiing, walking and dancing, as well as limited camping. She had been involved in business and on boards. She kept the house tidy which her husband now does and characterizes it as "a lot of work". She has to be helped to get into the bath tub, and wake up at night startled by pain which takes awhile to settle down.

[12] She was described as a very motivated person who had hoped to work to age 65. She had owned and managed three flower shops, although some time before the accident. She now found walking from one room to another a chore, but generally said very little about her pain any more.

Treatment

[13] Following the accident, she was initially provided with physiotherapy for her neck and leg. Her physician then referred her for assessment by a multidisciplinary team, which recommended secondary daily treatment with psychological support and education as to stages of tissue healing. The team documented mechanical pain and dysfunction of all three spinal levels, cervical, thoracic and lumbar, which they characterized as related to the injury, and "problems possibly related to injury" as being a flare up of her pre-existing fibromyalgia, a flare up of her pre-existing knee pain and a flare up of irritable bowel syndrome. They identified a number of problems unrelated to the accident, including the three conditions which flared up, stress, and degenerative changes in the cervical spine.

[14] She received secondary treatment at Daniels Kimber Physiotherapy Clinic beginning January 21, 2002. She was then on the urgent list for knee replacement surgery, and her activities were limited by left knee pain. Despite this, she participated in the program up until the scheduled knee surgery on March 5, with improvement in her shoulders. However, the degenerative changes in her knees made gym programming difficult, with minimal improvement in lifting and pushing. She did participate in a pool therapy program for overall strengthening.

The knee surgery interfered with a planned graduated return to work. Following rehabilitation for her knee, it was recommended that she continue with secondary programming, or have further assessment for tertiary programming for ongoing chronic problems with her neck, back and shoulders.

[15] The latter option was adopted: she attended the FIT for Active Living program for assessment on November 6 and 7, 2002, with pain from surgery in her left knee and leg, and in addition, similar pain in her right knee. The knee surgery had not been very successful, with a dropped foot, pain and inflammation in the knee. She was still having right-sided neck and shoulder pain, wrist and thumb pain (both hands), arm pain and sleep disturbance. The members of the FIT team recommended (after orthopaedic review to clear her knee status) active treatment at a tertiary level for 12 weeks, since she had not returned to pre-MVA level of function, the comorbidities² were negatively impacting her recovery, and her pain seemed out of proportion to the injuries incurred.

[16] The Appellant began the tertiary program on February 4, 2003 and was treated until March 4, 2003. At that point she was discharged on a temporary basis to help her sort out medical concerns related to pain, sleep disturbance, and wrist pain.

[17] The treatment team stated:

“Maximum Medical Improvement (MMI); (Further conservative therapeutic intervention will not significantly improve function. The client may improve through participation in home or community based programs.)

The client has reached MMI. The client has not demonstrated pre-motor vehicle accident level of function.

Prognosis:

Client did not demonstrate ability to benefit from active treatment in four week trial at FIT. Prognosis is limited by pre-accident conditions – osteoarthritis of wrists and knees, including left knee replacement, prior to MVA. Conditions directly related to MVA are not major barriers to resuming former function.”

² i.e. the knee problems and fibromyalgia.

[18] She had made no functional gains since admission. To allow her to participate in active rehabilitation at a therapeutic level, she needed to improve her sleep patterns and pain management.

[19] She was then referred to Arthur Grey Consultants Inc. for coordination of services in rehabilitation following the discharge. On March 10 she and her family physician approved a new rehabilitation plan providing for weekly acupuncture treatments to alleviate pain, client-physician discussion on medication for sleep patterns and pain management, and to determine her readiness to resume the active rehabilitation program.

[20] On April 1, 2003, there was a conference at FIT including the professionals who had been part of the FIT treatment team: the rehabilitation coordinator, physical therapist, occupational therapist, exercise therapist and psychology staff member, as well as the SGI personal injury representative, Al Dybvig, to determine if the Appellant should be readmitted to the FIT program. It was decided that if she were, she would need 10 weeks in the program to reach her pre-MVA level of function, by meeting weekly goals on a four week trial basis. If the goals were not met, then she would be discharged at that point. The problem in achieving the goals were her comorbid conditions, i.e. osteoarthritis, knee problems, wrist problems.

[21] It was agreed to ask the Appellant if she would attend under those conditions, and if so, agree to fully and actively participate. If she did not commit to do so, the program would be a waste of everyone's time. The team then met with the Appellant who advised them that since she had been at home and without exercise or rehabilitation other than acupuncture, she felt a lot better and didn't hurt as she had when in the program. The program was grueling for her and she forced herself to attend. She said that she did not want to continue with the program "nothing personal but she hurt so bad". She advised that Dr. Bernacki had suggested she should wear splints on her hands and arms on a daily basis, and that she thought that she had infection in her knee which might require surgery.

Medical Review of File

[22] Dr. John Alport, SGI's medical consultant, testified by telephone. He had reviewed the Appellant's medical file prior to the hearing.

[23] He compared the condition of her cervical spine as seen on the x-rays in 1998 and the x-rays done after the June 13, 2001 MVA. The former describes a subluxation of C4 3 mm forward on C5; the latter a ventral slip of C4 on C5, later described by the neurosurgeon as about 3 mm reducible subluxation. Although this showed the x-ray findings were pre-existing, he acknowledged that the soft tissue injuries to her neck were caused by the motor vehicle accident.

[24] The initial goal of the physiotherapy which she began two months post-accident was to improve her cervical stabilization and range of motion.

[25] Dr. Alport confirmed what Darrell Mack for SGI had already acknowledged, that SGI was not relying on the September, 2001 practitioner's report to justify its decision to terminate benefits in 2003, particularly since there had been no attempt to follow up with Dr. Wall, who provided the report.

[26] He referred to the January, 2002 multidisciplinary assessment, identifying the accident-related and non-accident-related conditions discussed above at paragraph [14]. He found it more helpful on the job duties she actually performed at the funeral home and as caregiver at [employer] than the Occupational Therapy Job Site Analysis done in February, 2002. Her position with [employer] had job demands ranging from sedentary (companionship positions, in which individuals require someone to drive them for coffee, to get groceries, or watch them when they're at home sleeping) to medium (helping clients to bed, to the bathroom, into the bath tub). He stressed that the Appellant had told the therapist she believed she had the physical ability to perform the job demands of companionship worker at this point in time. An assessment was also done of her work at the [funeral home], where physical demands varied greatly, from cleaning, vacuuming, moving stacked chairs, moving caskets, to flower arranging and spending time with clients.

[27] He emphasized that the January, 2002 report then said she had only “mild disability” for these jobs, had a high perception of pain, and had almost recovered from accident-related injuries. Her major disability was related to her knee problems.

[28] He had tried to follow up on the reference to the diagnosis of fibromyalgia by Dr. Olszynski,³ but it had been done so long ago that the record was no longer available.

[29] The initial assessment at FIT for Active Living at Saskatoon City Hospital in November, 2002 followed her difficulties in the secondary program interrupted by knee surgery. The recommendation was for an orthopaedic review on her knees to clear her for active treatment at a tertiary level for the MVA-related problems. Dr. Alport stated he felt the recommendations in this report and the tertiary treatment itself were getting a little far afield, in that SGI’s mandate was to rehabilitate from conditions related to the MVA.

[30] Dr. Alport had provided his medical review of the file to SGI on October 14, 2003.

[31] He identified the initial problems from the emergency room physician report, the neurosurgical consult, the x-ray and the July 12 neurosurgical consult.

[32] He referred to a chart comment that she had “almost recovered from accident-related injuries, and that they were nearly able to return to her work”.⁴

[33] In fact, the Daniels Kimber reports are quite pessimistic on her prognosis, with the discharge report of March 13, 2002, stating:

“[The Appellant] had minimal improvement throughout the seven to eight weeks that she was on program... She had not attempted a GRTW at this point due to the fact that she was not functionally ready to participate in the GRTW...”

IS FURTHER TREATMENT REQUIRED:

Yes. Although [the Appellant] did make some positive gains with regards to her cervical, thoracic, and lumbar spine, she did have persistent stiffness and myofascial tightness associated at

³ mentioned in Dr. Markland’s report.

⁴ Despite careful review, this comment has not been located in the documents filed, in particular the Daniels Kimber reports. There is a remark, apparently by SGI, that “she was almost ready for a return to work when she was hurt during treatment at Daniels Kimber.” This remark may be based on a document seen by Dr. Alport and SGI but not filed.

these three spinal levels. She also continued to have bilateral shoulder impingement; therefore, further treatment is required at a time when it is appropriate after her total knee replacement.”

[34] He commented on the complexity of her overall medical condition, with SGI’s failure to adjudicate its responsibility between accident related versus non-accident related problems. He expressed the view that most of her disability was clearly related to the latter, i.e. her bilateral knee pain. In his opinion there was no evidence that the accident caused any injury to her knee.⁵ We agree, even though the Appellant did say that her knee pain was worse after the accident.

[35] He observed that there was poor information about the pre-existing diagnosis of fibromyalgia, and little information since the accident indicating that the fibromyalgia was significantly worse, until her family physician’s very recent report of January 11, 2004, referring to a chronic pain syndrome and a fibromyalgia syndrome, and depression exacerbated by the fibromyalgia syndrome, her failure to be back at work, her osteoarthritis and the knee replacement, all of which appear to have developed after he had said in April, 2003 that there was no medical reason she could not return to work.⁶ He observed that there was no evidence she attended anyone because of a flare up of the fibromyalgia.⁷

[36] He concluded there was no evidence she had a disabling injury to the right shin, shoulder, left thumb or neck, the “accident related injuries”. While she was disabled by her ongoing knee problems, they were unrelated to the collision. None of the accident related injuries was sufficient to disable her from what he characterized as very sedentary jobs.

[37] In his testimony, however, Dr. Alport acknowledged that there had been little diagnostic work with respect to her shoulder(s), although there are a number of references in the chart to these problems, e.g. in August, 2001, January through March, 2002, November, 2002, March,

⁵ For example:”In the tibia and fibula there was moderate degenerative changes affecting the medial compartment of the knee and patellofemoral compartment. No bone or soft tissue injuries were detected.”

⁶ Dr. Wall explained this by saying he thought he would be helping her in the long run by encouraging her to return to work, but may have been premature in doing so as her injuries were not yet healed completely and she was still suffering chronic pain.

⁷ For example, she was referred to Dr. Markland, a rheumatologist, but for painful knees. Dr. Markland notes an earlier diagnosis of fibromyalgia, but does not comment on it. She does report limited cervical range of motion, and discomfort in the right paraspinous thoracic region.

2003. Some of these describe limitation in range of motion, others refer only to pain or weakness.

[38] The Appellant testified that her shoulder was hurt during physiotherapy at Daniels Kimber. She said she tore a muscle in her right shoulder, while exercising her neck and shoulders, although she was unable to recall what activity she was doing when she was hurt. The only documentation on this point is a brief reference, referred to in paragraph [32]. In our opinion, more evidence of causation than this is required before the insurer becomes liable for an injury incurred in the course of treatment. (As we stated in *E.A. v. SGI*⁸ and *A.I. v. SGI*,⁹ based on the reasoning in *Deibert v. Giddings*,¹⁰ SGI should bear the responsibility for injuries suffered by a customer while partaking in a form of treatment, where the risks of medical error or misadventure are reasonably foreseeable and not too remote.)

[39] Dr. Alport stated that shoulder pain is often related to fibromyalgia. In view of the foregoing, it may well be that the condition of the Appellant's shoulder(s) is not such as to disable her from performing the job duties she had at [employer] and the funeral home. We believe, however, that this issue should be specifically addressed by SGI and its consultants.

[40] The evidence concerning her wrist(s) is similarly confused and confusing. There is a brief mention of a sore left wrist at the time of the accident. An x-ray done of her left thumb refers to degenerative changes affecting the trapezium first metacarpal joint. The next reference is in November, 2002, in the FIT Initial Assessment, which speaks of bilateral wrist and thumb pain and weakness, and osteoarthritis of the metacarpal phalangeal joint bilaterally (exacerbated by MVA).¹¹ Finally, the FIT Discharge Report of March, 2003 shows no change in bilateral wrist and thumb pain and weakness (evaluated by the client) and no change in "osteoarthritis of metacarpophalageal joint bilaterally (exacerbated by MVA)" assessed by FIT. They then state: "Prognosis is limited by pre-accident conditions – **osteoarthritis of wrists** and knees, including

⁸ 2004 SKAIA 020.

⁹ 2004 SKAIA 018 in paragraphs [17] to [19].

¹⁰ 2003 SKQB 533.

¹¹ Also: marked irritability but fair stability around the first carpometacarpal joint bilaterally; wrists and fingers had normal range of motion, but giveway weakness on testing; some OA changes of the 1st MCP

left knee replacement, prior to MVA. Conditions directly related to MVA are not major barriers to resuming former function.”

[41] The Commission is left with the distinct impression that the Appellant may have had osteoarthritis in her wrist(s) at the time of the accident, that the accident in some way did make her wrist(s) worse, but that they were not too much of a problem until well over a year later. As with the Appellant’s shoulders, it may be that the condition of her wrists would not be a barrier to her resuming her pre-accident employment. The FIT Discharge Report, however, implies that the wrist osteoarthritis may be such a barrier.

[42] **As a result of our conclusions with respect to her shoulders and wrists, we set aside SGI’s decision terminating income replacement benefits on the basis that the information relied on by SGI failed to take into account whether or not her shoulder(s) or wrist(s) would disable her from resuming former function, and because the FIT report, in particular, stated that her prognosis was limited by osteoarthritis of her wrists, which had been exacerbated by the accident.**

[43] The Appellant requested that SGI retrain her. If it is her knees (non-MVA-related) that disable her from returning to work, SGI is not responsible for this.¹² If she is disabled from returning to work because of her shoulders or wrists, we expect that SGI would then consider this point.

[44] It should be noted that SGI *did* pay the Appellant a permanent impairment benefit of \$2,600 pursuant to the old no fault benefits available under Part II of *The Automobile Accident Insurance Act*, which was in force in 1993 at the time of the crush injuries to her knees. The \$2,600 represented a 26% whole body impairment of the then maximum \$10,000 available. (This compares with a maximum of \$125,000 indexed available when Part VIII of the *Act* came into force in 1995.)¹³

joints bilaterally; tenderness but no evidence of any acute inflammation at the base of the thumb and the first MTP (sic) joint.

¹² *The Automobile Accident Insurance Act*, in force before August 1, 2002, sections 110, 131, 132, 134.

¹³ Section 157.

[45] The Appellant was upset that SGI characterized her as non-compliant with treatment recommendations, by a warning letter sent by the SGI Personal Injury Representative, and by memo the PIR sent to Bourassa and Associates complaining about her lack of commitment, her uncooperative attitude, and her trips to British Columbia and to Winnipeg. As the warning letter was not filed, it is difficult to comment on it. We accept, however, that the assessors and treatment providers consistently refer to her cooperation and good attendance in the various programs. The Appellant acknowledged that she had gone to B.C. in a collar brace, with three overnight stops (not quite the 18 hour drive contemplated by the PIR), and said she had told her caregivers at Daniels Kimber, although not her PIR, about her proposed trip to Winnipeg with her daughter. In summary, the Commission was left with the impression that the SGI PIR and the Appellant did not get along well, and that she did get along well with others, but there is simply not enough evidence (which either side could have made available) for us to make any decision on this issue.

[46] The Appellant is entitled to the return of her application fee and her reasonable travel expenses in attending the hearing.

Dated at Regina, Saskatchewan, on June 14, 2004.

Ann Phillips, Q.C., Chair

Beverley Cleveland, Commission Member

Al Knippel, Commission Member