

**Automobile Injury Appeal Commission
Province of Saskatchewan**

Citation: *H.I. v. Saskatchewan Government
Insurance, 2007 SKAIA 055*
Date: 20070402
File: 170 of 2004

BETWEEN:

H.I., Applicant

and

Saskatchewan Government Insurance, Respondent

Appearances:
Ronald G. Gates, Q.C., for the Applicant
Elizabeth A. Flynn, for the Respondent

Before: **Ann Phillips, Q.C., Chair**
Beverly Cleveland, Commission Member
Stephanie Pfefferle, 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 Regina, Saskatchewan
September 20, 2005

DECISION

[1] As indicated in his Appeal Application Form, the Appellant, H.I., appeals the decisions of Saskatchewan Government Insurance (hereinafter referred to as “SGI”) set out in two letters, dated October 7, 2004 and October 28, 2004. The October 7, 2004 letter terminated funding for further treatments and associated expenses on the basis that SGI was not responsible for his current symptoms. This letter also specifically stated that a permanent impairment benefit was not owing as a result of the vestibular concussive syndrome suggested by Dr. Pillay in June 2004. The second letter, dated October 28, 2004, addressed the calculation of the Appellant’s income replacement benefit (hereinafter “IRB”) based on new information provided to SGI. We note that this does not constitute a proper decision letter as it does not provide written notice of the right to ask for mediation or the right to appeal the decision as required by subsection 189(1) of The Automobile Accident Insurance Act, R.S.S. 1978. c. A-35, as amended (hereinafter the “Act”). In any event, the Appellant conceded that he did not dispute the manner in which the IRB calculation was made and no appeal was pursued in this regard.

PRELIMINARY ISSUES

(a) Jurisdiction

[2] An issue arose at the hearing as to whether the Appellant missed the appeal period with respect to the termination of his IRB. The Appellant took the position that he has appealed the termination of his IRB in time. He contended that the letter terminating his IRB is the decision letter dated October 7, 2004, and the right to appeal the termination of those benefits, therefore, runs ninety days from the date of that letter. The Appellant’s Appeal Application Form was dated December 2, 2004 and was received by the Automobile Injury Appeal Commission on December 6, 2004. The appeal, therefore, is timely: the issue is whether the subject matter of termination is contained in that letter.

[3] To support his position, the Appellant made reference to the earlier letter of January 28, 2004, which was written apparently to clarify the results of a meeting on January 22, 2004 between the Appellant and his personal injury representative, Garth Cowling. This letter stated that: “[b]ased on the information that we have on file, it does not appear that you are entitled to receive an Income Replacement Benefit....The information that we have at this time indicates that you did not suffer a loss of income as a direct result of your motor vehicle accident.” The

letter explained that SGI was in the process of gathering medical reports regarding the Appellant's further medical problems and that once all of the information had been obtained, the file would be forwarded to SGI's medical consultant to determine if these problems are accident-related. The letter then stated:

I will then be in a position to determine whether or not you are entitled to a further Income Replacement Benefit.

Once I have received your file back from our Medical Consultant, I will be sending you a follow up letter that will outline SGI's decision regarding future benefits that you may be entitled to. The follow up letter will also include a copy of our Consultant's report, along with the opportunity for you to appeal SGI's decision.
[Emphasis added]

[4] The Appellant was of the view that SGI did not send out a letter advising him of his right to appeal the termination of his IRB until the letter of October 7, 2004. The Appellant pointed out that a note created by Michelle Sparrowhawk, personal injury representative for SGI, on September 10, 2004 acknowledged that no letter had been sent out regarding his ability to appeal this decision or advising him of this decision. Ms. Sparrowhawk's "File Review" note reads as follows:

File Review

Sept 10, 2004 in reviewing this file notes on line and letters sent out as well as medical info

my understanding is that we will look at topping up what we paid him if provides info for the 12 weeks he was paid. Not able to look at lengthening out irb as missed appeal time line.

see letters sent April 19, July 14, July 16 to which we did not respond July 16th letter.

Vehicle registered to [employer one] – I need to look into WCB in case coverage available.

Dr. Endsin reviewed file in March 2004 and injuries and problems not working are NOT related to the MVA and related to pre-existing problems. NO LETTER SENT TO HIM RE: APPEAL THIS DECISION OR ADVISING HIM OF THIS DECISION. I WILL LOOK AT SENDING HIM OUT A LETTER AFTER I DISCUSS FILE WITH DWAIN.

[5] The October 7, 2004 decision letter reads as follows:

This letter is to advise you of SGI's decision regarding your entitlement to benefits.

In past conversations I advised you our Medical Consultants would review your file. The Consultant has reviewed your file including new medical information received to date. It has been decided SGI is not responsible for any TMJ symptoms or treatment at this time. The consultant advised these symptoms were not mentioned or documented until many months after the accident and therefore would be unrelated. The Consultant also indicates that the suggestion of a vestibular concussive syndrome by Dr. Pillay in June of 2004 would also not be related to this accident and a permanent impairment benefit is not owing to you. It is documented by Dr. Rehman and Dr. Shawush that following the accident you did not experience a loss of consciousness. Your physical exams showed no evidence of neurological impairment. Dr. Rehman indicates that in his opinion your headaches may be related to cervical degenerative disc disease he also makes mention of your neurological exam being normal. Lastly, it was reported that your degenerative changes can not be accounted for by this collision and your persistent symptoms are likely attributed to the degenerative changes that pre-date this motor vehicle accident and may also be related to your past occupational history.

Please be advised that SGI will no longer participate or provide funding for any treatment or associated expenses. This decision must be reconsidered if any new relevant information is presented.....

[6] This letter specifically refers to treatment and associated expenses and to a permanent impairment benefit. It does not refer to the IRB.

[7] We note that at the time of the January 28, 2004 letter, the Appellant had already requested mediation with respect to the decision letter of September 18, 2003, which clarified the calculation and the basis of his IRB and stated that: “[t]hese benefits are also only payable for the period of time that it is medically substantiated that you are unable to perform the duties surrounding your farming position.” In his letter requesting mediation, dated December 8, 2003, the Appellant stated:

Please accept this as my request for mediation. Enclosed is a cheque for \$40.00.

Issues respecting the claim:

1. To use 52 weeks prior to the claim of the accident rather than the basis that was used.
2. Not using my welding income if that position was not held at the time of the accident.
3. **The benefits are only payable for the period of time that is medically substantiated that I am unable to perform the duties surrounding my farming position.**

[Emphasis added]

[8] It is apparent that at this point in time, the Appellant was aware that his IRB was only being paid for a specific period of time and, in this letter, he specifically requested that this issue be dealt with at mediation.

[9] At the hearing and in its brief of law, SGI took the position that the Appellant was advised that his IRB was terminated effective October 16, 2003 and that he was advised of his right to appeal or to proceed to mediation. While neither party was able to locate or produce a copy of this decision letter, SGI made reference to a “note to file” that apparently indicates this. This “note to file,” however, is simply an entry on an “Injury Claim Summary Sheet,” created October 14, 2003, that reads as follows:

Check for Discontinuance of Empl Pd Benefits
Due Date: 16-Oct-2003
Description: Not required...self employed.

In our view, this note is ambiguous at best.

[10] It is our finding that the mediation process, which followed the Appellant’s December 8, 2003 letter, is determinative of the issue whether the Appellant appealed the termination of his IRB within the time limit.

[11] On April 19, 2004, SGI sent the Appellant two letters. The first reads as follows:

At mediation you raised the *[sic]* of your Income Replacement Benefit.

A review of your claim for income benefits has been done. The calculation remains the same as was outlined in my August 14th, 2003 letter to you....

Based on the medical information that we have on file, SGI has agreed to fund an Income Replacement Benefit to you for a twelve week period after your motor vehicle accident.....

[Emphasis added]

[12] The second letter, dated April 19, 2004, stated as follows:

We understand that you disagree with SGI's position of only funding your Income Replacement Benefit for a twelve week period following your motor vehicle accident. We also understand that you do not agree with the amount of the payment that was made to you April 19th, 2004 as outlined in a letter of the same date.

Should you wish SGI to further review **the amount paid to you on your income replacement benefit**, I have been asked by our calculation unit to have you provide SGI with more information.

...

At this time, SGI is not prepared to change the calculation that was done previously. If you want SGI to review this matter, I have been asked that you provide the following information for our calculation team to review.

....

Once this information has been provided, I will forward your file to our calculation unit to have them review and determine whether or not **the amount payable** changes or not. You will then be notified by certified mail as to our decision.

[Emphasis added]

[13] In our view, these letters indicate that both the period of entitlement and the calculation of the amount of the IRB were dealt with at mediation. The second letter leaves the question with respect to the calculation of the amount of the IRB open for review in the event that further information was provided.

[14] On April 20, 2004, the mediator sent out a letter, pursuant to subsection 190(8) of the Act, declaring that mediation was complete. In accordance with subsection 191(1)(b) of the Act, the Appellant had sixty days after the date of this letter to appeal SGI's decision.

[15] On April 21, 2004, SGI wrote to the Appellant advising that its position remained unchanged and mediation was at a close. This letter also stated:

If you disagree with this decision you have a right to appeal to the Automobile Injury Appeal Commission or to the Court of Queen's Bench. You should now have received a letter from the mediator concluding mediation. **If you wish to appeal, you must do so within 60 days of the mediator's letter.**

[Emphasis added]

[16] In accordance with the above, the Appellant had until June 20, 2004 to appeal the IRB entitlement period. As noted earlier, however, the Appellant's Appeal Application Form was

dated December 2, 2004 and was received on December 6, 2004. The Appellant clearly missed the appeal period.

[17] The case law is clear that the Commission has no jurisdiction to extend or grant relief; the failure to file an appeal on a timely basis under section 191 of the Act is fatal.¹

[18] In light of the arguments advanced by both parties in their briefs of law, however, we will offer the following comments on the correspondence that took place between the parties following the conclusion of mediation.

[19] It appears that at one point in time both parties operated on the basis that the appeal period expired ninety days following the close of mediation, despite the fact that the sixty-day appeal period was clearly outlined in SGI's April 21, 2004 correspondence.

[20] On July 14, 2004, Counsel for the Appellant sent a letter to SGI stating that they had received instructions from the Appellant to appeal: "...this April 20, 2004 decision to the Court of Queen's Bench" and incorrectly noting that the: "...90 days to appeal expires on Monday, July 19, 2004."

[21] That day, SGI sent a letter to the Appellant's counsel as a follow up to a conversation with their office. The letter stated as follows:

This is to confirm that mediation on this file has concluded, and that I have instructed Chris that your company should make plans to move ahead with the next step of the appeal procedure. SGI is not prepared to waive or change any time frames that have been set out in any previous correspondence.

[22] On July 16, 2004, the Appellant's counsel sent another letter to SGI, which reads as follows:

This will confirm our telephone conversation of this date that my client will submit the information requested of him in your letter of April 19, 2004. This information was not submitted earlier due to the fact that [the Appellant] has only recently completed and filed his 2003 tax return.

My understanding is that this information would be considered not only with respect to the two week IRB amount of \$900.40 but also with respect to the decision of funding this IRB for a 12 week period. In that event, the commencement of the 60 day limit to the Automobile Injury Appeal Commission or Court of Queen's Bench, on either or both issues, would not commence until your review of the fresh information is completed.

Kindly advise if this is not your understanding of the present status of the matter.

¹See *Mintzler v. SGI*, 2000 SKQB 104 and 2001 SKCA 54. *Mintzler* was considered and applied in *K.F. v SGI*, 2004 SKAIA 006.

[23] SGI did not respond to this letter. However, an “Injury Note,” created on July 16, 2004, by Mr. Cowling summarized his telephone conversation with the Appellant’s counsel. The note stated, in part, as follows:

He said that he had received the letter that I sent regarding the time frames etc. **He said that they have already missed the time frame for the 990.00 part of it, but wanted to know if that would still be included once we decided whether to pay longer than the 12 weeks. He said that they are both so closely related that it would seem that they should be together.** I told him that I could not give him a definite answer but that I spoke to Dwaine and he said that IF [the Appellant] is still going to supply SGI with more information, then we would look at the calculation again. So it would appear that we are still flexible on the amount paid out, but not the length of time he was entitled to payments. Kirk is going to get some information ready and send it over to us. Once that is here, we can send the information back to the calculation unit and have them review the amount that was paid to [the Appellant] in the past for his IRB.

[Emphasis added]

[24] At the hearing and in its brief, SGI took the position that it did not need to respond to the July 16, 2004 letter. SGI submitted that it is not incumbent on it to continue to reiterate its position. The limitation periods were clearly set out in the April 21, 2004 correspondence. SGI was of the view that the July 16, 2004 letter from the Appellant’s counsel was simply self-serving. SGI asserted that its willingness to consider the calculation of the Appellant’s IRB in light of new employment information should not be viewed as a waiver of the appeal time lines, nor should it be seen as opening up all aspects of the decision i.e. the entitlement to an IRB beyond the twelve-week period, especially since this decision would be based on entirely different criteria than the calculation aspect of the decision. SGI argued that if this were allowed, it would render the statutory appeal process in the legislation meaningless. In accordance with the legislation, SGI is required to provide the insured a decision letter outlining the reasons for its decision and notice of the appeal procedure. The insured then has the opportunity to appeal that particular issue in accordance with the statutory appeal procedure. In the event that the insured elects not to appeal that decision or fails to do so in a timely fashion, the decision must stand. If not, SGI asserted that there would be no resolution or finality to SGI’s decisions and, as a pragmatic matter, this would render the entire claims process unworkable. SGI outlined that it is constantly making a number of decisions on a file and one decision is often predicated upon another.

[25] In our view, despite the fact that legal counsel was involved, SGI should have responded to the July 16, 2004 correspondence out of courtesy as the insurer and in an effort to minimize misunderstandings. The course of correspondence that ensued and the resulting misunderstandings, however, do not change the fact that the statutory appeal period had expired

prior to the commencement of correspondence between SGI and the Appellant's counsel. We do not have jurisdiction to consider the income replacement benefit termination.

(b) Admissibility and Weight of Dr. Endsins's Opinions

[26] Counsel for the Appellant submitted that Dr. Endsins's opinions should be disregarded or, in the alternative, given reduced weight since Dr. Endsins is paid by SGI to author his reports and he is not an unbiased participant in these proceedings.

[27] The primary test for admissibility of evidence in proceedings before the Commission is relevance. Subsections 196.3 (1) and (2) of the Act provide as follows:

s. 196.3(1) In the case of a hearing or review before the appeal commission, the appeal commission may receive any evidence that, in the opinion of the appeal commission, is relevant to the matter being heard or reviewed.

(2) The appeal commission is not bound by rules of law concerning evidence.

[28] Dr. Endsins's reports and testimony directly address the issue of the Appellant's entitlement to benefits. His reports were relied on by SGI in its decision to terminate or deny benefits. As such, they are clearly relevant to the issues in this appeal.

[29] In terms of Counsel for the Appellant's argument that Dr. Endsins's opinions should be afforded reduced weight, we are of the view that the weight given to a medical report is affected by a number of factors, one of which is the allegation of bias or lack of objectivity. Every medical report must be assessed and weighed on its merits against the individual circumstances of the particular case. The weight afforded to Dr. Endsins's opinions in this case is addressed in the "Law and Analysis" section of this decision.

[30] However, we note that in the case at hand, Dr. Endsins provided his opinions following a review of the Appellant's medical file, which included numerous reports and clinical notes provided by his own treating practitioners, both before and after the MVA; the police report; witness statements; repair estimates; photographs; and other expert reports. As such, we are of the view that the information upon which Dr. Endsins's opinions are based is reliable. Further, we note that the documents reviewed by Dr. Endsins were available to the Appellant so that the Appellant could test the accuracy and reliability of the information at the hearing. In addition, Dr. Endsins's curriculum vitae was included on the appeal file and Dr. Endsins testified in person

at the hearing. He was extensively cross-examined by the Appellant's Counsel.² Dr. Endsin's answers were responsive and thoughtful.

[31] Counsel for the Appellant also argued that because Dr. Endsin did not meet or examine the Appellant, he must defer to the Appellant's treating physicians regarding diagnosis.

[32] We are of the view that the fact that Dr. Endsin did not treat or personally examine the Appellant does not affect the admissibility of his reports. Dr. Endsin reviewed SGI's entire medical file and formulated his opinions on that basis. The fact that his opinions may be based on "second-hand information" goes to the question of weight as opposed to admissibility. As stated by the Saskatchewan Court of Appeal in *Rieger v. Burgess*:

[a]n expert, like any other witness, may testify as to the veracity of facts of which he has first-hand experience, but this is not the main purpose of his or her testimony. An expert is there to give an opinion. And the opinion more often than not will be based on second hand evidence....

The value of a psychiatrist's opinion may be affected to the extent to which it may rest on second-hand source material; but that goes to the weight and not to the receivability in evidence of the opinion which opinion is no evidence of the truth of the information but evidence of the opinion formed on the basis of that information.....

....the decision does stand for the position that the second-hand nature of the basis of the opinion does not 'contaminate' the opinion. This is consistent with the acceptance of expert evidence based, as it often is, upon hypothetical questions. For the judge or jury, the expert's opinion is a question of fact which may be accepted or rejected as seen fit. The opinion, even if uncontradicted, is not determinative of an issue.³

[27] In our view, a review of Dr. Endsin's testimony reveals that he agreed that he deferred to the Appellant's treating physicians with respect to their findings on physical examination and their differential diagnoses within their areas of expertise. However, he also cautioned that specialists usually only deal with a portion of the issue and may be unaware of the whole picture. He testified that often specialists may only have the referral letter on their file, which may or may not provide a summary of investigations, results and differential diagnoses. Thus, specialists may often place a great deal of reliance on the subjective history provided to them by the patient. The accuracy of this history is not always investigated. As a result of the foregoing, Dr. Endsin stated that he does not accept their opinions with respect to the issue of causation.

(c) Admissibility and Weight of Carl Shiels' Report

[33] In addition, the Appellant's counsel questioned whether the report of Mr. Carl Shiels should be accepted by the Commission.

²Furthermore, in our view, Dr. Endsin's qualifications and credibility were not strenuously disputed and the question as to

[34] As noted above, the primary test for admissibility is relevance.

[35] Mr. Shiels was specifically requested by SGI to provide his opinion as to how the Appellant's body would have moved as a result of the collision and to identify the potential for injury as a result of these movements.

[36] Mr. Shiels' report discusses: the impact velocity changes of the vehicles involved in the collision; how the Appellant's body would have moved as a result of the forces involved in the collision; and the potential for injury as a result of these movements. As such, the report addresses issues that are in dispute in the case at hand and, therefore, is relevant and admissible.

[37] In addition, we note that Mr. Shiels' curriculum vitae was included on the appeal file. Furthermore, while he did not testify at this particular hearing, he has testified before the Commission and the Court of Queen's Bench for Saskatchewan, on a number of occasions.

[38] In his report, dated June 13, 2005, Mr. Shiels asserted that the only significant forces on the driver's body would have been produced by the forward pushing action of the seat. Mr. Shiels concluded as follows:

In conclusion, the damage sustained by the rear bumper of the Dodge, and the absence of damage sustained by either of the other vehicles, or by the front of the Dodge, indicates that the maximum **forward** Delta-V the Dodge is likely to have experienced would be about 13 km/h, and that the subsequent **rearward** Delta-V is not likely to have been more than about 8 km/h. In response to these accelerations, the driver of the Dodge would first have been forced rearward – relative to the vehicle's interior – against his seat, and then forward – but with far less potential for injury – against the lap and shoulder restraints. **Because of the limited amount of human test data for collisions beyond 8 km/h forward Delta-V, and because of the possible inadequacy of the head restraints in the Dodge, the possibility of some type of minor cervical strain injury from the rear impact cannot be ruled out for the driver of the Dodge. In my opinion, the likelihood of any type of injury to the head or brain would have been extremely remote.**

[Emphasis added]

[39] To support this conclusion, Mr. Shiels made a number of assumptions in his report, including the following: that there was no damage to the front of the [Dodge]; that there was no damage to the vehicle behind the Dodge, being [Volkswagen]; that there was no damage to the vehicle in front of the Dodge; that the damage to the rear of the Dodge was accurately depicted in the six photographs taken by SGI; and that the repairs to the Dodge were accurately described in the collision repair estimate, dated October 20, 2003.

[40] We also note that in calculating the Delta-V experienced by the Volkswagen, Mr. Shiels stated that the weight of the Dodge "...will have been underestimated if there was any special equipment installed to make it wheel chair accessible."⁴

[41] Counsel for the Appellant submitted that Mr. Shiels' assumptions regarding the damage to the Dodge and that there was no damage to the Volkswagen are incorrect. Counsel further took the position that there was no evidence that this was a low-impact collision.

[42] Mr. Shiels did not personally examine any of the three vehicles involved in the MVA. In ascertaining the damage to the vehicles involved in the MVA, he relied on documents and photographs provided by SGI. No photographs were taken of the Volkswagen following the MVA and no repair estimate was available with respect to that vehicle. Mr. Shiels assumed that there was no damage to the Volkswagen.

[43] At the hearing, the Appellant testified that there was damage to the Volkswagen. He stated that after the MVA, he noticed that the hood of the Volkswagen was overlapped. His statement to SGI, dated October 15, 2003, however, does not mention this damage. A Personal Injury Note, created by Diane Knash-Rapp, dated October 15, 2003, indicated that the Appellant stated that he noticed damages to the rear bumper but not to the front bumper of the Dodge and that he did not see any damage to the vehicle in front of him. There is no mention of damage to the Volkswagen. In addition, we note that the Appellant could not recall the crossroad where the MVA occurred. He testified that he was dazed at the time of the MVA.

[44] In light of the above inconsistencies, we prefer to rely on the Appellant's original statement to SGI.

[45] The Motor Vehicle Accident Report Form, dated July 18, 2003, noted that the driver of the Volkswagen did not report the accident. At the hearing, Mr. Cowling testified that no damages were claimed by the owner of the Volkswagen, but he also indicated that many at fault drivers do not get repair estimates if they believe the damages to be under \$750.

[46] Neither party called the owner nor the driver of the Volkswagen to confirm whether there was damage to the vehicle as a result of the MVA. As a result, the evidence is not clear on this issue.

⁴ Although the Dodge was identified as an accessible taxi van, it is not clear whether any "special equipment" was installed to

[47] Counsel for the Appellant also questioned the accuracy of SGI's reports regarding the extent of damage to the Dodge and took the position that there was damage to the frame of the Dodge as a result of the MVA.

[48] The SGI repair sheet, dated October 20, 2003, indicated that the damage to the Dodge involved \$147.52 in replacement parts and \$514.38 in labour for a total of \$789.25, including taxes. "Correction of frame damage" was listed and the part type was noted as "existing." It appears that this item accounted for \$107.66 from the total labour costs of \$514.38.

[49] At the time of the MVA, the Appellant was on his way to pick up a client in the Dodge, which was an accessible taxi van.⁵ A letter, undated, from [employer one] was filed on the appeal file regarding the Appellant's employment status and his good character while he worked as an independent contractor/driver for employer one.⁶

[50] We note that employer one testified that the Dodge was required to pass random comprehensive safety inspections at least once a year apparently because it was used as a public service vehicle. He stated that the Dodge passed those inspections before the MVA and, therefore, if there was frame damage prior to the MVA, he would have known it. Employer one stated that he was 99.99% certain that damage to the frame was caused by the MVA. On cross-examination, however, he acknowledged that there were no additional repairs required to the vehicle beyond those indicated on the SGI estimate, except that he had it re-painted. He also acknowledged that the Dodge had passed the safety inspections following the MVA quite a few times.

[51] While the evidence is not conclusive on the issue, there is evidence to indicate that the MVA was a low-impact collision. There is no dispute that there was no damage to the vehicle in front of the Dodge or to the front of the Dodge itself. It is possible that there was some frame damage to the Dodge, but given the amount of the repairs required, we would classify this damage as minimal.

[52] We are of the view that there are problems with the assumptions made in Mr. Shiels' report. Due to the fact that Mr. Shiels was not available at the hearing to address the impact of

make it wheel chair accessible.

⁵See above at paragraph 40.

⁶ A hand-written notation on the letter, reads as follows: "\$[illegible]256.12 Repair Work." However, this notation was not adequately explained at the hearing and its meaning is not clear to us.

these concerns on the conclusions set out in his report, we are not inclined to place significant weight on this report.

The Motor Vehicle Accident and the Application for Benefits

[53] The Appellant was injured in a motor vehicle accident on July 18, 2003 (hereinafter referred to as the “MVA”). He was the seat-belted driver of the Dodge, which was stopped at a red light and was rear-ended by the Volkswagen. The Dodge was then pushed into the car in front. The Appellant testified that he expected more damage but that he didn’t hardly see any. The drivers exchanged license plate numbers and the Appellant continued on his way to pick up a passenger. He then reported the MVA to the police. The Appellant testified that he was in a bit of a daze at the time of the MVA and did not realize he was hurt.

[54] A few hours following the MVA, the Appellant saw Dr. Rose, complaining of a headache, sore neck and a sore right arm. He was prescribed Baclofen and Voltaren and X-rays were taken of the cervical spine.

[55] In the Application for Benefits, dated August 8, 2003, the Appellant reported that his headaches, lack of balance and problems with sight in his right eye were his most severe injuries, with a level of pain of ten out of ten. On the pain diagram, the Appellant shaded in the front and back of his head and neck, as well as both shoulder areas. He indicated that he had also experienced tingling in his right hand, which went away, but was continuing to have bad headaches, sore neck and shoulders, and tearing and blurring in his right eye. He recorded that his headaches came with moving around or reading. The Appellant noted that he did not lose consciousness immediately after the MVA, but he did not know if he hit his head.

[56] A series of medical investigations and reports followed and will be discussed in detail below.

LAW AND ANALYSIS

Standard of Review

[57] The Commission’s jurisdiction to review a decision of SGI is set out in subsection 193(7) of the Act. The Commission may set aside, confirm, or vary the insurer’s decision. In addition, the Commission may make any decision that the insurer is authorized to make pursuant to Part VIII of the Act.

[58] The Saskatchewan Court of Appeal addressed the issue regarding the standard of review applicable to appeals before this Commission in *Allary v. Saskatchewan Government Insurance*, 2006 SKCA 89. In that case, the Applicant had put SGI's findings of fact in issue and, accordingly, the Commission had held a hearing pursuant to subsection 193(6) of the *Act*. In *Allary*, the Court of Appeal concluded that, where an appellant disputes SGI's decision regarding causation and places SGI's findings of fact in issue, the standard of review is correctness. The Court stated, in part, as follows:

[20] Where the facts are placed in issue, as they are here, the appeal commission has an obligation to receive and consider any new evidence submitted by the appellant and, depending on the nature of the hearing which is conducted, to consider as well the evidence received by SGI in making the finding of fact or facts in dispute on the appeal. The appeal commission must determine whether the decision of SGI was erroneous having regard to all the evidence. The factual issue for determination within the case was whether there was a causal link between the benefits claimed and the injuries caused by the accident of September 8, 2001.

[21] Notwithstanding its comments on the appropriate standard of review, the Commission in fact applied the proper standard, i.e. correctness. It conducted a hearing, heard the evidence of the appellant and reviewed the record including certain documentary evidence concerning the issue of causation to determine whether or not there was a causal link between the transportation benefits and mental health benefits claimed and the injury.

[59] The decision letter under appeal is dated October 7, 2004 and reads, in part, as follows:

In past conversations I advised you our Medical Consultants would review your file. The Consultant has reviewed your file including new medical information received to date. It has been decided SGI is not responsible for any TMJ symptoms or treatment at this time. The consultant advised these symptoms were not mentioned or documented until many months after the accident and therefore would be unrelated. The Consultant also indicates that the suggestion of a vestibular concussive syndrome by Dr. Pillay in June of 2004 would also not be related to this accident and a permanent impairment benefit is not owing to you. It is documented by Dr. Rehman and Dr. Shawush that following the accident you did not experience a loss of consciousness. Your physical exams showed no evidence of neurological impairment. Dr. Rehman indicates that in his opinion your headaches may be related to cervical degenerative disc disease he also makes mention of your neurological exam being normal. Lastly, it was reported that your degenerative changes cannot be accounted for by this collision and your persistent symptoms are likely attributed to the degenerative changes that pre-date this motor vehicle accident and may also be related to your past occupational history.

Please be advised SGI will no longer participate or provide funding for any treatment or associated expenses.
....

[60] Therefore, the primary issue before us is whether the Appellant's medical conditions, including the possible diagnoses of TMJ, vestibular concussive syndrome and/or post-concussion syndrome, as well as headaches and degenerative changes, were caused by or related to the MVA. During the hearing for this appeal, the Commission received and considered all of the evidence submitted by the Appellant and SGI. As held by the Court of Appeal in *Allary*, we will determine whether or not "... the decision of SGI was erroneous having regard to all of the evidence".

[61] A review of the evidence with respect to the Appellant's symptoms follows below. There will invariably and unfortunately be considerable overlap with respect to the evidence regarding these symptoms, and, therefore, there will be some repetition in the analysis.

Position of the Parties

[62] SGI submitted that the symptoms of the Applicant were based on his own subjective complaints and that there was a lack of objective medical evidence to establish that these symptoms were related to injuries sustained in the MVA. SGI argued that the only objective finding was the degenerative disc disease noted in the X-ray and MRI reports and that many of the Appellant's ongoing symptoms were consistent with the pre-existing degenerative disc disease. Further, SGI was of the view that there was no consistent diagnosis which linked these ongoing problems to the MVA. SGI took the position that the MVA exacerbated the degenerative disc disease and that the Appellant's ongoing problems were the result of the pre-existing degenerative disc disease or may be related to his occupational history.

[63] Counsel for the Appellant submitted that the Appellant's benefits were terminated just as the proper investigations and diagnosis of his injuries were commenced. Counsel was of the view that the medical evidence attributed the Appellant's ongoing injuries to the MVA; the Appellant either suffered from post-concussion syndrome or vestibular concussive syndrome or his condition has yet to be properly diagnosed. Counsel argued that there was no medical information to suggest that the Appellant was not disabled or injured as a result of the MVA.

The Appellant's Pre-Existing Condition

[64] Hours after the MVA, an X-ray of the Appellant's cervical spine was taken. The report, dated July 18, 2003, revealed:

There is straightening of the cervical vertebrae which can indicate muscle spasm. C5-6 and C6-7 **moderately advanced degenerative** disc changes are present. No acute abnormality is recognized. Atlanto-dens interval is normal. Vertebral marginal osteophytes partially encroach on the C5-6 and C6-7 neural foramina.

[Emphasis added]

[65] In the Application for Benefits, the Appellant reported that he had had a motor vehicle accident between ten and twelve years before in which he suffered neck/shoulder injuries and that he had had a Worker's Compensation or other insurance or disability plan claim regarding his lower back in the mid to late 1980s. He also noted that he had had chiropractic treatments

with Dr. Johnstone for lower back and hip conditions in the past five years prior to the MVA. He indicated that the date of his last treatment was eighteen months before the MVA.

[66] Dr. Johnstone, in a report to SGI, dated May 9, 2005, stated that he initially saw the Appellant in May 1986 for lower back pain and then in 1993 for mild occipital headaches after he twisted his neck. The area of dysfunction was at the right C2-3 level. In this report, Dr. Johnstone transcribed his clinical notes of the Appellant's prior chiropractic treatments, which outlined the following:

- a) on January 5, 2000, the Appellant attended Dr. Johnstone, complaining of right shoulder pain and episodic lower back pain and received treatments in the hip area and also for right sacroiliac joint dysfunction. He was treated again on January 10, 14 and 20, 2000;
- b) the Appellant was treated for right gluteal pain, right SI and lateral thigh pain on February 22, 2000;
- c) he was seen in September 2000 for pain in the mid-back;
- d) in November 2000, he presented with a headache of approximately three weeks' duration. It began at the base of the skull to the front and was relieved by lying down. Dysfunction was also noted at the right C2-3 facet;
- e) in December 2000, the Appellant was treated for a right C2-3 facet;
- f) in July 2001, he was treated for neck and lower back pain and headaches similar to those in November 2000. He was also treated for left sacroiliac and right C2-3 facet. On July 20 and 26, 2001, the right C2-3 facet was adjusted again;
- g) headache was noted on October 17, 2001, with discomfort at the cervicothoracic junction. The right C2-3 facet was treated, in addition to myofascial techniques for the suboccipital region;
- h) in December 2001, the Appellant was treated for lower back pain, and indicated that his neck had been "fairly good." The pelvis was adjusted and the right sacroiliac was treated; and

i) on May 21, 2002, he complained of bilateral lower back pain assessed as a left sacroiliac dysfunction.

[67] Dr. Johnstone stated that he did not treat the Appellant between May 21, 2002 and August 8, 2003.

[68] In our view, chiropractic treatment prior to the MVA was periodic at best and was not indicative of an active pre-existing condition.

[69] SGI's medical consultant, Dr. Endsins, testified at the hearing. He stated that he would be surprised if the Appellant did not experience any symptoms before the MVA given the degree of degenerative changes evident on the X-ray and the MRI reports. In Dr. Endsins's opinion, symptoms that may have been experienced by the Appellant as a result of the degenerative changes include headaches, stiffness in the range of motion of the neck, and numbness and tingling in the arms. However, at the hearing Dr. Endsins agreed that from May 21, 2002 and until the day of the MVA, there is no record of treatment and there is no evidence that the Appellant experienced any symptoms during that time.

[70] In his April 10, 2005 report, the Appellant's family doctor, Dr. Surtie, stated that: "[The Appellant] was well before the accident," and that "...the accident exacerbated his degenerative disc disease in his neck."

[71] At the hearing, Dr. Endsins stated that he accepted Dr. Surtie's statement that the Appellant was asymptomatic prior to the MVA. Dr. Endsins explained, however, that symptoms of degenerative disc disease may be intermittent and he was of the opinion that the MVA aggravated or provoked symptoms that were quiescent for a time period.

[72] It is clear that the MVA exacerbated the degenerative disc disease. The issue that must be determined is the degree to which it was exacerbated. Thus, the evidence with respect to the Appellant's symptoms must be examined.

Neck Pain

[73] As noted above, an X-ray of the Appellant's cervical spine was taken after the MVA. The report, dated July 18, 2003, revealed:

There is straightening of the cervical vertebrae which can indicate muscle spasm. C5-6 and C6-7 moderately advanced degenerative disc changes are present. No acute abnormality is recognized. Atlanto-dens interval is normal. Vertebral marginal osteophytes partially encroach on the C5-6 and C6-7 neural foramina.

[Emphasis added]

[74] In the Practitioner's Report, based on the July 24, 2003 examination, Dr. Surtie noted post-concussion headache, neck injury and tender right trapezoid. The neurologic examination was recorded to be normal, as was the spine examination, however, palpatory tenderness was noted over the midline of the cervical spine.⁷ Dr. Surtie reported that the Appellant still had low-grade headaches and that he was waiting for the CT scan result. Dr. Surtie prescribed massage therapy, Naprosyn, Amitriptyline and Lorazepam.

[75] In his report, dated August 1, 2003, Dr. Shawush, neurologist, diagnosed a mild whiplash injury. He noted that the Appellant developed neck pain and headache after the MVA, with some nausea and blurred vision, as well as numbness in the right hand. Dr. Shawush then stated that: "[o]verall his symptoms are improving. His headache is better in the last two days and he has no further numbness in his hands. His sleep is fine." Dr. Shawush noted that the general physical exam was "unremarkable" and that the Appellant was "...neurologically intact. He has no evidence of radiculopathy or neuropathy." Dr. Shawush concluded as follows: "I expect his neck pain to improve gradually with time." He stated that no further neurological investigations were necessary and suggested that the Appellant continue with Voltaren and consider massage therapy.

[76] In his letter to SGI, dated May 9, 2005, summarizing his clinical notes, Dr. Johnstone noted that on August 8, 2003, the Appellant's cervical ranges of motion were normal with pain in the right occipital region at the C3-4 level. The Appellant was treated for right C2-C3 facet on August 8, 11 and 15. Dr. Johnstone also advised that the Appellant was treated six additional times up to September 17, 2003. Unfortunately, these clinical notes were not transcribed and it is not clear what areas were treated.

[77] An X-ray of the cervical spine with obliques was taken on September 22, 2003. The report stated as follows: "[m]oderately advanced degenerative disc disease is noted at C5-6 and C6-7 associated with osteophyte formation which does impinge into the neural foramina bilaterally. No other significant bony disc or joint abnormality is identified."

⁷ This Practitioner's Report is dated October 27, 2003.

[78] The Appellant was referred to Dr. Rehman, neurologist, for complaints of headaches, poor balance and difficulty concentrating. In his report, dated December 2, 2003, Dr. Rehman noted that the “quite severe” headaches started to improve after massage therapy and that after five treatments of acupuncture therapy, the Appellant reported “feeling a lot better.” Dr. Rehman also reported that at this time, the Appellant denied “any neck pain.”⁸ However, in his later report of March 4, 2004, Dr. Rehman recorded that the Appellant stated that the neck and occipital pain, along with intermittent numbness and weakness of the right arm, returned within a few weeks after this visit. In the March 2004 report, Dr. Rehman also noted that the Appellant’s neck movements were full with mild pain on extreme lateral rotations and mild tenderness at the C7-T1 spinous process. Dr. Rehman reviewed the February 2004 MRI report and stated that he was “...surprised to see that there is quite severe disease of the cervical spine.” Dr. Rehman concluded that:

This gentleman has cervical myelopathy. His clinical features are very mild. However, I feel that the cervical disease have [*sic*] to be addressed at this point before it gets worse. I will seek a neurosurgery opinion. He may be help [*sic*] by laminectomy to prevent the progression of the disease. I am not sure if the right frontal headaches are related to the cervical degenerative disease, as I mentioned above. It could be post-traumatic headaches or stress headaches, but I feel that the major concern and issue at hand is the cervical myelopathy. I hope that I will be able to make [*sic*] neurosurgery opinion within a week or two.

[79] Dr. Surtie’s clinical note for January 5, 2004 stated that the Appellant “...continues to complain of soreness in his neck and a headache and experiences blurring in his right eye at times.”

[80] An MRI of the cervical spine was arranged to investigate “persistent neck pain.” The MRI Report, dated February 18, 2004, revealed:

At C6-7: There is severe degenerative disc disease characterized by marked loss of disc height and prominent marginal osteophyte formation. These marginal osteophytes result in severe bilateral neural foraminal stenosis and mild to moderate central canal stenosis. There is flattening of the adjacent spinal cord with evidence of some focal areas of increased signal centrally compatible with myelopathy. No evidence of a disc protrusion.

At C5-6: There is a similar pattern of severe degenerative disc disease characterized by prominent marginal osteophyte formation. There is a resultant severe bilateral neural foraminal stenosis and at least mild central canal stenosis. The spinal cord is flattened but no evidence of acute cord edema is seen.

At C7-T1: There is some mild degenerative disc disease characterized by marginal osteophyte formation but no evidence of significant central or neural foraminal stenosis. There is also some mild osteoarthritis in the posterior facets.

...

Impression:

⁸ This was noted in Dr. Agrawal’s report of December 31, 2004 as well.

Severe degenerative disc disease at C5-6 and C6-7 as described above. **The most important finding is the presence of mild central cord edema at the C6-7 level as a result of the cord compression caused by the degenerative changes. Because of this finding, neurological consultation is recommended.** There is also severe bilateral neural foraminal stenosis at both these aforementioned levels.

No evidence of disc protrusion at any level of the cervical spine.

[Emphasis added]

[81] On March 2, 2004, Dr. Surtie reported to SGI that the Appellant had been complaining of a post-concussion headache, a painful right eye with blurring vision and a problem with his balance since the MVA. He reported that on that date, the Appellant was having numbness in his right arm and persistent pain in his neck.

[82] The Appellant was seen by Dr. Nair, neurologist, on March 8, 2004. In his report of that date, Dr. Nair concluded that: “[m]ost of his arm paresthesia and imbalance is likely related to the central cord contusion. I think *[sic]* may spontaneously resolve but I am surprised it is six months and he still has the problem.” Dr. Nair noted that he had not seen the MRI at this point but understood the edema to be mild. He recommended an assessment by a neurosurgeon to “see if any intervention is needed.” Dr. Nair then concluded as follows: “I will leave the management of his neck problems which appears *[sic]* to be traumatic in the hands of the Neurosurgeon.”

[83] The Appellant returned to Dr. Rehman’s office on July 12, 2004. In his report of that date, Dr. Rehman noted that the Appellant was referred to Dr. Buwembo who had recommended surgery but that the Appellant advised that he “...feels that his neck symptoms are better. He is more worried about his vision problem.”

[84] Dr. Agrawal, neurologist, also noted this in his December 31, 2004 report. He stated that the Appellant “...was offered surgery for his radicular neck pain, but since his symptoms were improving he did not pursue anything further.” Dr. Agrawal noted that: “[h]e has not had any specific treatment and his MRI of the neck and MRI of the brain was reported as normal.”⁹ He further reported that at this time the Appellant “...denies any significant neck pain.” Dr. Agrawal recorded that the Appellant’s chief complaints were headache, fatigue, numbness in the arm, difficulties with balance and blurred vision. Dr. Agrawal concluded as follows: “I think his symptoms could be related to post-concussion syndrome. Given imaging studies has *[sic]* been normal, I do not think that we need to do anything further at this time. If he has not had

any B12, folate and TSH screening, he can be sent for those tests.” Dr. Agrawal also recommended a trial dose of Effexor as it “...can help his post-concussion symptoms, including mild depression¹⁰ and headache.” He also arranged for EMG testing to rule out carpal tunnel syndrome.

[85] On January 12, 2005, the Appellant visited Welsh & Associates, Physiotherapy & Acupuncture, for complaints of cervical, thoracic, lumbar, craniovertebral, shoulder, pelvic and TMJ pain. He recorded depression¹¹ and high blood pressure as medical problems. The Appellant reported that within hours of the MVA, he developed headaches, right temple and facial numbness, poor balance, blurred vision, right shoulder and neck pain and tightness. He noted that he gradually developed right hand tingling and numbness, in addition to fatigue and severe headaches coming on in the night associated with hot flashes. The Appellant also felt that his right eye pulled to the right and was concerned about falling due to his poor balance.

[86] In the Admissions Report, dated January 19, 2005, Ms. Jane Welsh, physical therapist, noted the Appellant’s physiotherapy/massage therapy diagnosis to be: “MVA with closed head injury, central nervous system injury. WAD II CSP, jaw, shldr - myofascial pain.”

[87] On assessment, Ms. Welsh noted:

1. Forward lean, flat Csp, asymmetry pelvis and shoulder girdle, long C and convex *[illegible]* lumbar. Felt *[illegible]* (R) shoulder elevated, med. rot. humerus, scapula ant. tilted. 2. Tension in the shoulder girdle, restricts scapular elevation upward rotation, retraction, protraction. 3. Cervical ROM – flex 90%, ext 60%, central pain, SB L v. R 90%, rotation (R) 75% pain, rotation (L) 80% pain (L). 4. Balance - positive Romberg eyes open and worse when closed, leans to right. Sharpened Romberg much worse < 10 seconds. 5. U.L. reflexes normal *[illegible]*. 6. Muscle tension suboccipitals csp paravertebrals, trapezius R > L. 7. TMJ reduced (L) jt translation – functional opening no sounds. Deviation *[illegible]* on opening. 8. Craniovertebral dysfunction – C1 (R) rotated, reduced (R) rot & SB. 9. PANAs questionnaire to determine depression/anxiety negative for either. 10. Disability scale rating 3/5. 11. Dizziness handicap inventory 64 – moderate with greatest handicap in functional area.

[88] Ms. Welsh concluded as follows:

I believe [the Appellant] demonstrates symptoms similar to post concussion likely due to the MVA. His disequilibrium seems related to cervical facet joint receptor disturbance and possibly a closed head injury. Altered body temperature and night sweats, fatigue, poor memory, heat in his head, blurred vision and severe headaches are all part of this.

[Emphasis added]

⁹ This is a curious statement given the MRI finding of severe degenerative disc disease at C5-6 and C6-7 with mild central cord edema at the C6-7 level and severe bilateral neural foraminal stenosis at both of these levels.

¹⁰The issue of depression was not specifically addressed by the parties.

¹¹As noted above the issue of depression was not raised by the parties. We note, however, that Ms. Welsh’s report did not identify a diagnosis of depression and that the PANAs questionnaire appeared to be negative for anxiety and depression.

[89] In her report, Ms. Welsh outlined a treatment plan for the Appellant involving treatments twice a week for 8-10 sessions. These treatments were to include: education, supportive position, ROM exercises, strengthening exercises, postural correction, soft tissue stretches, massage, muscle balancing techniques, intramuscular stimulation, laser, acupuncture, electrical stimulation, joint mobilization, gait re-education and balance training.

[90] We note that the Appellant began acupuncture and physiotherapy treatments on January 14, 2005 and continued with approximately twelve additional treatments, ending on September 2, 2005. The invoices do not indicate that the Appellant received the other treatments listed in the Admissions Report.

[91] We have a number of problems with Ms. Welsh's report. We do not know whether she examined the X-ray or MRI reports since she does not address the degenerative disc disease in her report. It is not clear from the report whether Ms. Welsh was aware of the Appellant's history of headaches, and neck and back pain. Under the headings "history" and "other," she simply recorded "[cancer] – urethra" and "MVA 10-12 years ago – recovered [with] minimal treatment." In addition, we note that she is a physical therapist and that she first examined the Appellant almost a year and one-half after the MVA. Her report indicated that the onset of the primary problem was the July 2003 MVA, which was described as follows: "[r]ear-ended while stopped, driven into car in front. Uncertain whether he hit his head. Memory of events foggy...." Other reports on the appeal file, indicated that the vehicle the Appellant was driving was "pushed" into the car in front of him. We note that this is consistent with the statement he provided to SGI on October 15, 2003. Ms. Welsh's assessment appears to imply that the MVA was a relatively forceful collision. Her understanding of the forcefulness of the MVA is presumably based solely on the Appellant's description. It is not clear how her understanding of the MVA affected the diagnoses and treatment plan outlined in the report. Further, we note that Ms. Welsh recorded objective findings with respect to areas that were not reported to be injured in the MVA: for example, the thoracic and lumbar spine, as well as the pelvic girdle. These are areas that Dr. Johnstone had treated in the past. In addition, Ms. Welsh also diagnosed a central nervous system injury, however, the nature of this injury is not clear from her report.

[92] On March 21, 2005, the Appellant attended the offices of Dr. Nair for follow-up. Dr. Nair's report of that date recorded that the Appellant's neck pain was better and that there was no neck stiffness.

[93] This is consistent with the Appellant's testimony. At the hearing, he stated that the range of motion in his neck was not "too bad" and that at the time his neck was not causing him problems. He acknowledged that he was scheduled for neck surgery, but then his neck started to feel better and since the surgery would not help with his vision and balance problems, which he believed were his primary problems at the time, he declined the surgery.

[94] Unfortunately, there is very little evidence on the appeal file regarding post-MVA treatment. We note that Dr. Johnstone treated the C2-C3 level both before and after the MVA. We also note that there is no evidence before us to indicate that Dr. Johnstone treated the Appellant for cervical spine symptoms after August 25, 2004.¹² Dr. Rehman, in his December 2003 report, indicated that the Appellant's headaches had improved following massage therapy and that after five treatments of acupuncture he was feeling "a lot better." In addition, as outlined above, Ms. Welsh provided acupuncture and physiotherapy in 2005.

[95] SGI's decision to terminate funding for treatment and associated expenses, as set out in the decision letter of October 7, 2004, was based upon the file review and opinions of its medical consultant, Dr. Endsin. Following his review of the file, Dr. Endsin concluded, in his March 30, 2004 report, that:

On review of the information it is my opinion that the significant degenerative changes that are present in the MRI report of February 18, 2004 predate the accident. Dr. Rehman, in his letter of December 2, 2003, suggested that the claimant's headache and neck symptoms at that time were related to stress not pathology and advised that he could return to normal function including work. Dr. Shawush, in his memo of August 1, 2003 indicates that the Claimant had suffered a previous motor vehicle accident 12 years prior to this one and this may account for the development of degenerative [*sic*] that are now seen on his cervical spine.

The MRI findings do suggest swelling and irritation of the central cord. This irritation certainly may be significant enough to prevent him from returning to his previous duties. The question that needs to be answered is whether his current symptoms are attributable to the motor vehicle accident or whether they are unrelated. It is clear from the chiropractic notes we have, that the claimant was having neck symptoms and headaches before the motor vehicle accident. **It is my opinion that the motor vehicle accident may have minorly aggravated this presentation and that SGI has at best only a partial responsibility for treatment.**

It is my contention that the reason he cannot return to work at this time has more to do with the long-standing degenerative osteoarthritic changes to his cervical spine that are not attributable to the above motor vehicle accident. Under normal circumstances any swelling or inflammation as a result of the motor vehicle accident should have settled down within a 6 week or at very most 12-week period following the motor vehicle accident. Following this any subsequent swelling and irritation is directly attributable to the previous degenerative changes and not the motor vehicle accident itself.

[Emphasis added]

¹² While we are aware that Dr. Johnstone saw the Appellant on January 29, 2004, February 27, 2004 and August 25, 2004, these clinical notes were not transcribed (except for the note for January 29, 2004) and it is difficult to determine what areas, if any, were treated.

[96] We have difficulty with this report for the following reasons. We note that Dr. Endsins indicated that Dr. Shawush's report of August 1, 2003, suggested that the earlier motor vehicle accident may account for the development of the degenerative disease. However, Dr. Shawush simply stated in that report that the Appellant "...had a history of whiplash injury 12 years ago." Dr. Endsins also indicated that Dr. Rehman, in his report of December 2, 2003, was of the view that the neck symptoms and headaches were related to stress. Dr. Rehman's report of that date, however, did not specifically assess neck pain presumably because at that time the neck pain was not in issue.¹³ In this report, Dr. Rehman was primarily focussed on the headaches and concluded that: "[t]he patient seems to be suffering from stress headache. I do not feel that these are migraines....and I feel that after the headache is improved the rest of the symptoms would also be better in the next few months." In his March 2004 report, Dr. Rehman stated that: "I saw him in December and diagnosed it as a stress headache with the possibility of posttraumatic [*sic*] headaches as well." In that report, Dr. Rehman amended his diagnosis to headaches possibly related to the cervical degenerative disease or post-traumatic headaches. Dr. Rehman assessed the Appellant on a third occasion and in his report, dated July 12, 2004, he stated that: "I feel that [*the Appellant*] is suffering symptoms of transformed migraine."

[97] In addition, Dr. Endsins did not address Dr. Nair's opinion that the Appellant's neck problems appeared to be "traumatic" and Dr. Nair's conclusion that: "[m]ost of his arm paresthesia and imbalance is likely related to the central cord contusion. I think [*sic*] may spontaneously resolve but I am surprised it is six months and he still has the problem." In addition, we note that on September 15, 2005, Dr. Nair stated that he needed further reports to "...say that I have not detected any problem related to the accident."

[98] Moreover, while Dr. Endsins, in his report of March 30, 2004, was of the opinion that "...the significant degenerative changes that are present in the MRI report of February 18, 2004 pre-date the accident," the MRI report, prepared eight months after the MVA, described the degenerative disc disease as "severe" and noted mild central cord edema at the C6-7 level, however, the X-rays taken immediately following the MVA classified the disc disease as "moderately advanced." We presume that these terms are specifically defined and utilized by the medical community and we are troubled by the possibility that such a significant change in the disc disease was not investigated further by either the Appellant's practitioners or SGI. We do not feel that this was adequately addressed by Dr. Endsins in his reports.

¹³At this time, Dr. Rehman noted that "[h]e denies any neck pain."

[99] In his March 30, 2004 report, Dr. Endsins made the following comments with respect to the MRI findings:

The MRI findings do suggest swelling and irritation of the central cord. This irritation certainly may be significant enough to prevent him from returning to his previous duties. The question that needs to be answered is whether his current symptoms are attributable to the motor vehicle accident or whether they are unrelated. It is clear from the chiropractic notes we have, that the claimant was having neck symptoms and headaches before the motor vehicle accident. It is my opinion that the motor vehicle accident may have minorly aggravated this presentation and that SGI has at best only a partial responsibility for treatment.

It is my contention that the reason he cannot return to work at this time has more to do with the long-standing degenerative osteoarthritic changes to his cervical spine that are not attributable to the above motor vehicle accident. Under normal circumstances any swelling or inflammation as a result of the motor vehicle accident should have settled down within a 6 week or at very most 12-week period following the motor vehicle accident. Following this any subsequent swelling and irritation is directly attributable to the previous degenerative changes and not the motor vehicle accident itself.

[Emphasis added]

[100] Further, in his May 10, 2005 report, Dr. Endsins described the importance of the presence of osteophyte formation as noted on the X-ray reports. He explained as follows:

The implication of osteophyte formation is that there has been a chronic inflammatory process involving the ligaments attaching one vertebrae to the next. Chronic inflammatory processes in these ligaments, as time goes by provoke a deposition of calcium as the body's means to solidify the ligament and prevent further injury. This calcium eventually bridges the joint and causes fusion of the spine in most cases. In this situation the osteophyte or calcium bridge which is starting to develop does cross the opening where the nerve comes out between two cervical vertebrae. The consequence for the claimant is that eventually this calcium bridge will become solid. As it grows it may press on the nerve root exiting through the foramina or opening and may cause other symptoms including sensory deficits or motor weakness.

[Emphasis added]

[101] Dr. Endsins also commented on the degenerative changes at C5-6 and C6-7 as noted on the MRI Report. He stated as follows:

This suggests that there is wearing out of the cartilage plate between two vertebrae, specifically the fifth and sixth and the sixth and seventh cervical vertebrae. The cartilage plate normally acts as a cushion. As the plate degenerates and wears out there is a loss of height of the space between these two vertebrae and eventually when it wears out completely you have rubbing of bone on bone. This promotes the development of a calcium bridge and will eventually lead to fusion. I believe Dr. Rehman in his March 4, 2004 report is discussing the irritation of the nerve roots as his definition of cervical myelopathy.

[102] In his March 30, 2004 report, Dr. Endsins further concluded that:

Under normal circumstances any swelling or inflammation as a result of the motor vehicle accident should have settled down within a 6 week or at very most 12 week period following the motor vehicle accident. Following this any subsequent swelling and irritation is directly attributable to the previous degenerative changes and not the motor vehicle accident itself.

[Emphasis added]

[103] It is not clear what Dr. Endsins meant by the phrase "under normal circumstances," however, the evidence indicates that the Appellant continued to complain of neck pain after the

six to twelve week period following the MVA. In his March 2004 report, Dr. Nair attributed the Appellant's arm paresthesia and imbalance to the central cord contusion and recommended that his neck problems, which Dr. Nair considered to be traumatic, be dealt with by a neurosurgeon. Neck pain was noted in January 2004 and "persistent" neck pain was noted to be the reason for the February 18, 2004 MRI. "Persistent" neck pain was reported by Dr. Surtie again in March 2004. While we acknowledge that the neck pain was intermittent, the Appellant was referred to a neurosurgeon following the MRI and surgery was recommended. We also note that the Appellant was seen by Dr. Johnstone on January 29, 2004, February 27, 2004 and August 25, 2004,¹⁴ and received acupuncture and physiotherapy treatments.

[104] Other symptoms identified at the hearing by Dr. Endsin as possibly related to the degenerative changes include headaches and numbness and tingling in the arms. The evidence with respect to these symptoms is discussed below.

[105] However, we conclude that the evidence does suggest that the MVA aggravated the existing "moderately advanced" degenerative disc disease so that it came later to be described as "severe", and indeed, that the central cord was contused or bruised to such an extent that surgical intervention was recommended. We are satisfied that these were not "normal circumstances", and in any event, that SGI is responsible for treating "actual circumstances" rather than normal ones. SGI is certainly entitled to consider what is "normal" in reaching its decisions about treatment, but it must treat a real patient and not a hypothetical one. In the Appellant's case, SGI did treat a real patient: the appropriate referrals generally seem to have been made. In causation issues, while it is also appropriate to consider what is "normal", we expect the opinion to deal with the "actual" as well.

[106] We are of the view that the acupuncture and physiotherapy treatments provided by Dr. Johnstone and Ms Welsh likely did relate to neck pain, which flared up during a period that could be reasonably considered attributable to the original recovery. We order that these be reviewed by SGI on the basis that the treatments were necessary or advisable.

[107] Since neck pain was not a problem for the Appellant at the time of the hearing, two years after the MVA, we conclude that the exacerbation of his condition by the MVA is no longer a causative factor. He will likely continue to have neck pain on what we hope is no more than an

¹⁴Since these clinical notes were not transcribed (except for the note of January 29, 2004), it is difficult to ascertain what areas, if any, were treated.

occasional basis, but we are of the view that the role of the MVA in accelerating the degenerative disc disease has been accounted for.

Numbness and Tingling

[108] In the Application for Benefits, the Appellant noted that he was having tingling in his right hand but that it had gone away. This was recorded in Dr. Shawush's report of August 1, 2003 and Dr. Rehman's report, dated March 4, 2004, as well.

[109] In his report of March 4, 2004, Dr. Rehman noted that the Appellant stated that the neck and occipital pain, along with intermittent numbness and weakness of the right arm, returned within a few weeks after his visit in December. Dr. Rehman reviewed the February 2004 MRI report and stated that he was "...surprised to see that there is quite severe disease of the cervical spine." Dr. Rehman concluded that:

This gentleman has cervical myelopathy. His clinical features are very mild. However, I feel that the cervical disease have *[sic]* to be addressed at this point before it gets worse. I will seek a neurosurgery opinion. He may be help *[sic]* by laminectomy to prevent the progression of the disease. I am not sure if the right frontal headaches are related to the cervical degenerative disease, as I mentioned above. It could be post-traumatic headaches or stress headaches, but I feel that the major concern and issue at hand is the cervical myelopathy. I hope that I will be able to make *[sic]* neurosurgery opinion within a week or two.

[110] On March 2, 2004, Dr. Surtie reported to SGI that the Appellant was having numbness in his right arm and persistent pain in his neck.

[111] Dr. Nair, in his report of March 8, 2004, noted that the right neck exercises advised by Dr. Rehman increased the numbness in the arm. On examination, Dr. Nair found that the Appellant had "...impaired pain and to some degree vibration in his right arm up to the elbow. The left arm is normal." Dr. Nair concluded that:

Most of his arm paresthesia and imbalance is likely related to the central cord contusion. I think *[sic]* may spontaneously resolve but I am surprised it is six months and he still has the problem.... He has no myelopathic physical findings.

...

With regards to management I think it is a good idea for him to see a neurosurgeon and see whether any intervention is needed. The edema is reported to be mild but I have not seen the MRI.

[Emphasis added]

[112] In his report, dated July 12, 2004, Dr. Rehman noted that the Appellant had stopped taking the Topamax he had prescribed after feeling paresthesias. The location of the paresthesias is not clear from this report. However, Dr. Rehman stated that his neurological

examination was normal and concluded: “I feel that he is suffering symptoms of transformed migraine.”

[113] In his December 31, 2004 report, Dr. Agrawal noted that the Appellant was concerned about the intermittent numbness in his arm, headache, fatigue, difficulty with balance, and blurred vision. Dr. Agrawal stated that: “[h]e has not had any specific treatment and his MRI of the neck and MRI of the brain was reported as normal.”¹⁵ Dr. Agrawal concluded as follows: “I think his symptoms could be related to post-concussion syndrome. Given imaging studies has *[sic]* been normal, I do not think that we need to do anything further at this time. If he has not had any B12, folate and TSH screening, he can be sent for those tests.” Dr. Agrawal recommended a trial dose of Effexor as it “...can help his post-concussion symptoms, including mild depression and headache.” He also arranged for EMG testing to rule out carpal tunnel syndrome with respect to the recurrent tingling and numbness in the Appellant’s hand.

[114] On March 21, 2005, the Appellant returned to Dr. Nair’s office. At that time, the Appellant reported that the tingling and numbness was better. Dr. Nair also noted that the MRI of the head failed to show any abnormality and that the nerve conduction and EMG study of his right arm failed to show any peripheral neuropathy, radiculopathy or plexopathy.

[115] On September 12, 2005, Dr. Nair was contacted by counsel for SGI and a letter was sent to him confirming their telephone conversation. Dr. Nair indicated that he could not identify any physical findings attributable to or causing the Appellant’s current physical complaints, in particular dizziness and imbalance. At that time he had not identified any cognitive problems and had recommended an assessment by Dr. Landry. In addition, Dr. Nair agreed that the Appellant’s condition remained essentially undiagnosed.

[116] On September 15, 2005, Dr. Nair indicated that he overlooked two points. He stated as follows:

When I was talking to you and signed the report, I over looked two points. I have seen this gentleman in March 2004. **When he had Neurological deficits with tingling and loss of some sensation in the right arm. He also had imbalance. I attributed this to the swelling (showing he likely had an injury to the spinal cord in the neck). I expected this to get better, but suggested neurosurgical consult. When I saw him on March 21, 2005 he had only imbalance but his numbness had improved.** His main complaint was memory problem *[sic]* and unsteadiness which I could not detect. **He also complained about episodes of loss of vision for which I arranged ultrasound test of brain circulation. Also I have not received Neuropsychologist’s opinion.**

¹⁵ This is a curious statement given the MRI finding of severe degenerative disc disease at C5-6 and C6-7 with mild central cord edema at the C6-7 level and severe bilateral neural foraminal stenosis at both of these levels

I need these reports to say I have not detected any problem related to the accident.

[Emphasis added]

[117] As noted above, Dr. Endsln testified that symptoms that may be experienced by the Appellant as a result of degenerative changes could include numbness and tingling in the arms. Dr. Endsln indicated that symptoms of degenerative disc disease could be intermittent in nature.

[118] There is no evidence before us recommending treatment for this symptom. Further, the Appellant advised at the hearing that the numbness and tingling had resolved, however, the Appellant noted that occasionally his right arm “falls asleep.”

[119] We conclude that the MVA did cause the numbness and occasional tingling, not experienced before. As with the neck pain, these symptoms have resolved. We do not have any basis to believe that the Appellant requires further treatment, or that this constitutes a permanent impairment.

Headaches

[120] In the Application for Benefits, the Appellant listed headaches to be one of his most severe injuries. He noted that following the MVA, the pain was as severe as it could be. He indicated that if he moved around, read, or stood up he got bad headaches. He recorded that he could not remember whether he hit his head but noted that he did not lose consciousness immediately after the MVA.

[121] In the Practitioner’s Report, dated October 27, 2003, Dr. Surtie indicated that he examined the Appellant on July 24, 2003 and diagnosed post-concussion headache and neck injury, as well as a tender right trapezoid. He prescribed massage therapy, Ibuprofen, Amitriptyline and Lorazepam. Dr. Surtie reported that drowsiness due to medications and low-grade headaches were the medical reasons for the Appellant being unable to participate in normal activities, including work.

[122] In his report, dated August 1, 2003, Dr. Shawush noted that the Appellant’s headache was better in the last two days and he stated that: “[o]verall his symptoms are improving.” Dr. Shawush reported that there was nothing remarkable in the physical examination and there was no evidence of radiculopathy or neuropathy. He concluded that there was no need for any further neurological investigation and diagnosed a mild whiplash injury.

[123] The Appellant was referred to Dr. Lwanga, internalist, for headaches.¹⁶ In his September 22, 2003 report, Dr. Lwanga noted that at that time, the Appellant reported that the headache was mostly on the right side of the head and had been present for three weeks without ceasing. Before this, the headache came and went. It became worse as the day progressed and he occasionally experienced blurred vision. The headache was not associated with nausea or vomiting. The Appellant advised that sometimes the headache would wake him up at night and he would feel sweaty all over. Dr. Lwanga reported that the Appellant's gait, co-ordination and speech were normal and that there was a slight drooping of the left upper eyelid. He recorded that the visual testing did not reveal any deficits. Under the heading "Assessment," Dr. Lwanga stated: "1. Headache – cause NYD 2. Systematic illness eg. Hypertension, etc." Dr. Lwanga concluded as follows:

Differential Diagnoses:

1. POST CONCUSSION SYNDROME
 - a). Cluster headaches/Migraine variant
 - b). One has to rule out intracranial lesions
2. Borderline blood pressure

He recommended a check of sedimentation rate, a CT scan of the head, CBC, and ambulatory blood pressure monitoring and prescribed Valium with Elavil.

[124] On October 22, 2003, the Appellant had a CT scan, which did not identify a "significant intracranial abnormality."¹⁷

[125] On December 2, 2003, Dr. Rehman noted that the Appellant had experienced quite severe headaches for three weeks that started to improve with massage therapy. He felt better for a few weeks and then the headaches started to recur. The Appellant described a pulling of the right eye with pain that spread to the whole head. He reported that he was feeling better after five acupuncture treatments and that his headache pain score was now two out of ten. Dr. Rehman concluded that the Appellant:

... seems to be suffering from stress headache. I do not feel that these are migraines. He has improved markedly. Concentration problems and mild balance problems are sometimes associated with stress headache and I feel that after the headache is improved the rest of the symptoms would also be better in the next few months. I have encouraged him to return back to work and to participate in daily activities even though he does not feel 100% okay. I briefed him about stretching exercises and local application of the heat. His neurological examination is normal and I do not expect any structural abnormality of the brain.

¹⁶It is not clear to us why the Appellant was sent to Dr. Lwanga for investigation into his headaches since Dr. Lwanga is an internalist.

¹⁷ It was interpreted as normal.

[126] On March 2, 2004, Dr. Surtie wrote to SGI that the Appellant had been complaining of a post-concussion headache, a painful right eye with blurring vision and a problem with his balance since the MVA.

[127] On March 4, 2004, Dr. Rehman examined the Appellant again. In his report, Dr. Rehman stated: "I saw him in December and diagnosed it as a stress headache with the possibility of posttraumatic [*sic*] headaches as well." Dr. Rehman then noted the MRI results and stated as follows: "I am surprised to see that there is quite severe disease of the cervical spine." Dr. Rehman was unable to provide a clear diagnosis with respect to the headaches; he stated: "I am not sure if the right frontal headaches are related to the cervical degenerative disease, as I mentioned above. It could be posttraumatic [*sic*] headaches or stress headaches, but I feel that the major concern and issue at hand is the cervical myelopathy."

[128] In his report, dated March 8, 2004, Dr. Nair concluded as follows: "...he seems to have a headache which could be a form of cluster headache. In this case this could be post traumatic."¹⁸ Dr. Nair recommended Verapamil to control the cluster headache.¹⁹

[129] Dr. Rehman saw the Appellant again on July 12, 2004. In his report of that date, Dr. Rehman noted that the neurological examination was normal and stated that: "I feel that he is suffering symptoms of transformed migraine." Dr. Rehman prescribed Valporic Acid.

[130] In his December 31, 2004 report, Dr. Agrawal noted that the Appellant experienced headaches if he did not get twelve hours of sleep. He noted that the Appellant had headaches seven to ten days in a month and that they were not associated with nausea, vomiting, or photophobia. The Appellant took Tylenol or Motrin to relieve the headaches. Dr. Agrawal noted that the headaches were mostly on the right temporofrontal region. Dr. Agrawal stated: "I think his symptoms could be related to post-concussion syndrome. Given imaging studies has [*sic*] been normal, I do not think that we need to do anything further at this time. If he has not had any B12, folate and TSH screening, he can be sent for those tests." Dr. Agrawal also recommended a trial dose of Effexor as it "...can help his post-concussion symptoms, including mild depression and headache."

¹⁸ We note that Dr. Nair was aware of the MRI results at this time but apparently had not seen the actual report.

¹⁹ We note that Dr. Lwanga had initially mentioned cluster headaches in his report of September 22, 2003.

[131] We note that Dr. Agrawal commented that the MRI of the neck was “reported normal.” It appears that Dr. Agrawal did not personally review the MRI report of February 18, 2004 at that time. If he did, it is not clear why he discounted the severe degenerative disc disease at C5-6 and C6-7 with mild central cord edema at C6-7 and severe bilateral neural foraminal stenosis at both levels.

[132] In the Admissions Report of January 19, 2005, Ms. Welsh described the Appellant’s headaches as: “...severe headaches coming on in the night associated with hot flashes. (R) eye pulls to (R).” We note that her report identified TMJ findings, however, she appeared to attribute the headaches to the possible post-concussion syndrome. She concluded that:

I **believe** [the Appellant] demonstrates symptoms **similar** to post concussion **likely** due to the MVA. His disequilibrium **seems** related to cervical facet joint receptor disturbance and **possibly** a closed head injury. Altered body temperature and night sweats, fatigue, poor memory, heat in his head, blurred vision and severe headaches are a part of this.

[Emphasis added]

[133] It is not clear from her report whether any of the many treatments she recommended were intended to address the symptom of the headaches.

[134] For the reasons outlined in paragraph 91 above, and especially given the absence of any reference to the degenerative disc disease, we are unable to place significant reliance on this report.

[135] On March 21, 2005, Dr. Nair examined the Appellant again. At this time, the Appellant stated that the headaches had improved and that his primary problems were poor balance, blurry and watery vision, poor memory and concentration. Dr. Nair stated: “I will arrange for him to have an ultrasound of the carotid because of the sudden loss of vision he is complaining about without headache on the right side.”

[136] In assenting to the contents of the September 12, 2005 correspondence, Dr. Nair indicated that he could not identify any physical findings attributable to or causing the Appellant’s current physical complaints. In addition, Dr. Nair agreed that the Appellant’s condition remained essentially undiagnosed.

[137] On September 15, 2005, Dr. Nair indicated that he overlooked two points. He stated as follows:

When I was talking to you and signed the report, I over looked two points. I have seen this gentleman in March 2004. When he had Neurological deficits with tingling and loss of some sensation in the right arm. He also had imbalance. I attributed this to the swelling (showing he likely had an injury to the spinal cord in the neck). I expected this to get better, but suggested neurosurgical consult. When I saw him on March 21, 2005 he had only imbalance but his numbness had improved. His main complaint was memory problem [*sic*] and unsteadiness which I could not detect. He also complained about episodes of loss of vision for which I arranged ultrasound test of brain circulation. Also I have not received Neuropsychologist's opinion.

I need these reports to say I have not detected any problem related to the accident.

[138] In his most recent report, dated April 10, 2005, Dr. Surtie did not specifically address the cause of the headaches. However, he appeared to link the Appellant's ongoing symptoms to the TMJ or the exacerbation of the degenerative disc disease. In his April 10, 2005 report, Dr. Surtie concluded that:

I am of the opinion, based on the continuing nature of the symptoms he is experiencing that he needs of [*sic*] continuing care. It is probable that he has TMJ as a result of the accident as he had no symptoms prior to the accident, and the accident exacerbated his degenerative disc disease in his neck.

[139] Dr. Surtie had earlier identified a superficial head injury in his clinical note for July 24, 2003,²⁰ listed "post-concussion headache" as a primary diagnosis in his Practitioner's Report of October 27, 2003, and referred to post-concussion headaches in his clinical notes. In addition, on March 2, 2004, Dr. Surtie reported that the Appellant had been complaining of a post-concussion headache, a painful right eye with blurring vision and a problem with his balance since the MVA.

[140] The Appellant testified that he never had headaches before the motor vehicle accident in 1991 or 1992. Following this accident, he had severe headaches for a couple of months that gradually decreased until they resolved.

[141] In a note, dated February 20, 2004, Dr. Johnstone indicated that he saw the Appellant approximately eleven times between September 6, 2000 and May 21, 2002 for headaches (right suboccipital), pain in the lower back and neck, as well as right C2-3 facet.

[142] In his letter of May 9, 2005, Dr. Johnstone indicated that he last treated the Appellant with respect to headaches on October 17, 2001, approximately twenty-one months before the MVA.

[143] On March 30, 2004, Dr. Endsing concluded that:

²⁰ Dr. Rose also recorded superficial head injury in the January 5, 2004 clinical note.

.... It is clear from the chiropractic notes we have, that the claimant was having neck symptoms and headaches before the motor vehicle accident. It is my opinion that the motor vehicle accident may have minorly aggravated this presentation and that SGI has at best only a partial responsibility for treatment.

It is my contention that the reason he cannot return to work at this time has more to do with the long-standing degenerative osteoarthritic changes to his cervical spine that are not attributable to the above motor vehicle accident. Under normal circumstances any swelling or inflammation as a result of the motor vehicle accident should have settled down within a 6 week or at very most 12-week period following the motor vehicle accident. Following this any subsequent swelling and irritation is directly attributable to the previous degenerative changes and not the motor vehicle accident itself.

[144] In his September 29, 2004 report, Dr. Endsinn reiterated that Dr. Johnstone's chart notes indicated that there had been chiropractic treatment for headaches and neck pain as far back as November 2000. Dr. Endsinn concluded that:

It is my opinion that the claimant's symptoms by and large are unrelated to the motor vehicle accident of *July 18, 2003*. **The claimant's ongoing headaches appear to pre-date the motor vehicle accident as he required frequent chiropractic treatment for such symptoms prior to the motor vehicle accident.** As mentioned in my memo of March 30, 2004, although the motor vehicle accident may have potentially aggravated his symptoms we would expect that following a six to twelve week period, at maximum. He would be at his pre-accident state and the persisting symptoms would not be related to his pre-existing health issues.

....

It is my opinion that his persistent symptoms are likely attributable to the degenerative changes that pre-dated his motor vehicle accident and may also be related to his past occupational history.

[Emphasis added]

[145] In his testimony, Dr. Endsinn noted that Dr. Johnstone drew a connection between the headaches and the Appellant's neck problems. In light of this and given the extent of the pathology shown on the MRI and X-ray reports, Dr. Endsinn concluded that the headaches were linked with the pre-existing degenerative changes to the cervical spine. He was not certain to what degree the MVA exacerbated the Appellant's pre-existing symptoms, for which treatment had been sought in the past, but Dr. Endsinn reiterated that the pre-MVA headaches were similar to those experienced post-MVA and Dr. Endsinn emphasized that they had been treated similarly.

[146] We note that Dr. Johnstone treated the C2-3 level both before and after the MVA. When asked why Dr. Johnstone's physical findings revealed problems at a higher level, i.e. C2-3, than the levels C5-6 and C6-7 where the "moderately advanced" or "severe" disc disease was found on the X-ray and MRI reports, Dr. Endsinn could not explain the disparity except to state that those were Dr. Johnstone's findings and that he was not certain whether Dr. Johnstone had access to the radiological reports or whether he was relying on his physical findings alone. Dr. Endsinn also stated that Dr. Johnstone simply may have been mistaken regarding the site of involvement if he did not have the benefit of the MRI or X-ray reports. Dr. Endsinn further

stated that he preferred to rely on the opinion of the neurologist in term of the location of the degenerative changes. We agree.

[147] Dr. Endsins testified that it is difficult to determine the pathology of headaches. Often one cannot find any pathology, in which case, one is left with a “fall-back” diagnosis, as opposed to a conclusive objective finding. He agreed that sometimes one has a better idea what is going on later, rather than earlier, because with headaches one needs to rule out everything else first. Dr. Endsins noted that in this case there is no pathology in the brain and, therefore, it is possible that the cause of the headaches may never be identified. He was unable to explain what Dr. Rehman meant by the term “transformed migraine,” however, he stated at the hearing that migraines are usually a vascular problem and are not linked to trauma.

[148] Dr. Endsins agreed at the hearing that from October 17, 2001 up to the MVA in 2003, there was no record of treatment for headaches. However, Dr. Endsins also stated that he would have been surprised if the Appellant did not experience any headaches given the degree of degenerative changes evident on the X-ray and the MRI reports. He testified that the non-existence of symptoms, in light of the identifiable pathology, did not fit with his clinical experience. Dr. Endsins would have expected symptoms such as headaches, stiffness and reduced range of motion of the neck, and numbness and tingling in the arms as a result of the degenerative changes in the neck.

[149] Dr. Endsins admitted that he accepted Dr. Surtie’s statement that the Appellant was asymptomatic before the MVA because Dr. Surtie would have had to satisfy himself that that was the case. However, he did not accept Dr. Surtie’s conclusion that the Appellant’s ongoing symptoms were all related to the MVA. He stated that Dr. Surtie’s April 10, 2005 report was simply a summary of symptoms and the objective findings upon which his opinions were based are not outlined in that report.

[150] The Appellant testified that he continues to experience headaches but that he is getting better slowly. He noted that after the MVA, he would have a headache and then experience vision problems. Currently, however, he stated that the headaches are a result of the vision problems.

[151] The Appellant further testified that he noticed that activities during harvest, such as combining or swathing, causes headaches and that during harvest he was unable to read or

watch TV. But, in the summer when he is not doing farm work, he is able to read the paper and watch TV. Driving into the sun also causes headaches, but his prescription sunglasses help with this. He stated that “eye motion” seems to bother him; he can do manual labour but activities involving motion, such as combining, bother him. In addition, he stated that he cannot drive at night or weld as the lights bother him. The Appellant testified that he will get headaches if he tries to “get under” equipment to work or do repairs. If he does not pace himself at work, he will get a headache and will be unable to work the next day. The Appellant also stated that if he has twelve hours of sleep a night, he does not experience headaches. The Appellant testified that he takes Tylenol for his headaches. He stated that he took four Tylenol the night before the hearing. He believed that his headaches are probably caused from activities related to combining i.e. watching for rocks and watching the feed.

[152] The only treatment that has been recommended for the Appellant’s headaches is medication. We note that the Appellant currently takes Tylenol for the headaches and tries to avoid the activities which appear to trigger the headaches.

[153] The headaches, by themselves, have not been definitively diagnosed, but they seem to be of declining importance. However, given the equivocal nature of the medical evidence, we are unable to conclude, on the evidence before us, that SGI’s decision letter of October 7, 2004 is correct that the Appellant’s “persistent [*headache*] symptoms are likely attributed to the degenerative changes that pre-date this motor vehicle accident and may also be related to [*his*] past occupational history.”²¹

Post-Concussion Syndrome

[154] The decision letter under appeal stated, in part, as follows:

The Consultant also indicates that the suggestion of a vestibular concussive syndrome by Dr. Pillay in June of 2004 would also not be related to this accident and a permanent impairment benefit is not owing to you. It is documented by Dr. Rehman and Dr. Shawush that following the accident you did not experience a loss of consciousness. Your physical exams showed no evidence of neurological impairment. Dr. Rehman indicates that in his opinion your headaches may be related to cervical degenerative disc disease he also makes mention of your neurological exam being normal.

[155] The decision letter does not specifically mention post-concussion syndrome despite the fact that this was diagnosed or referred to by some of the Appellant’s practitioners: for example, Dr. Surtie, Dr. Lwanga, Dr. Agrawal, and Dr. Johnstone. We further note that Dr. Endsins was

asked to address the diagnosis of post-concussion syndrome and did so in his report to SGI dated May 10, 2005. Therefore, the evidence with respect to post-concussion syndrome is discussed below.

[156] Dr. Surtie noted “post-concussion headache,” neck injury and tender right trapezoid in his Practitioner’s Report, dated October 27, 2003, based on the July 24, 2003 examination. He recorded that the neurologic examination was normal and stated that he was waiting for the CT scan result. Dr. Surtie prescribed massage therapy, Naprosyn, Amitriptyline and Lorazepam.

[157] The clinical note for July 24, 2003 identified a superficial head injury and a neck brace was recommended, as well as a referral to Dr. Shawush.²²

[158] Dr. Shawush was the first neurologist to see the Appellant. In his report, dated August 1, 2003, Dr. Shawush noted that the Appellant did not lose consciousness and did not go to the hospital following the MVA. He recorded that, at that time, the Appellant reported neck pain, headache, loss of balance and numbness in his right hand, as well as mild nausea and blurred vision. Dr. Shawush stated that: “[o]verall his symptoms are improving.” Dr. Shawush reported that there was nothing remarkable in the physical examination and there was no evidence of radiculopathy or neuropathy. He stated that there was no need for any further neurological investigation. Dr. Shawush provided a diagnosis of mild whiplash injury.

[159] As noted earlier, the Appellant was sent to Dr. Lwanga for further investigation of his headaches. In his report, dated September 22, 2003, Dr. Lwanga noted headaches with occasional blurred vision as the Appellant’s primary complaint. He listed the following under the heading “Assessment:” “1. Headache – cause NYD 2. Systematic illness eg. Hypertension, etc.” and offered a differential diagnoses of:

1. **POST CONCUSSION SYNDROME**
 - a). Cluster headaches/Migraine variant
 - b). One has to rule out intracranial lesions
2. Borderline blood pressure
[Emphasis added]

Dr. Lwanga recommended a check of sedimentation rate, a CT scan of the head, CBC, ambulatory blood pressure monitoring and prescribed Valium with Elavil.

²¹In fact, we do not understand the reference to “past occupational history” except insofar as it may relate to the possibility that the hearing loss and/or tinnitus was related to the Appellant’s past employment history (welding).

²²Dr. Rose also recorded superficial head injury in the January 5, 2004 clinical note.

[160] On October 22, 2003, the Appellant had a CT scan, which did not identify a “significant intracranial abnormality.”²³

[161] The Appellant was examined by another neurologist on December 2, 2003. In his report of that date, Dr. Rehman noted that the Appellant had improved markedly and that his neurological examination was normal. He reported that the physical examination revealed no sensory motor impairment and that the Appellant exhibited normal co-ordination and gait. Dr. Rehman was of the opinion at that time that the concentration and mild balance problems could be related to the stress headaches. He concluded that the Appellant:

... seems to be suffering from stress headache. I do not feel that these are migraines.... Concentration problems and mild balance problems are sometimes associated with stress headache and I feel that after the headache is improved the rest of the symptoms would also be better in the next few months. I have encouraged him to return back to work and to participate in daily activities even though he does not feel 100% okay. I briefed him about stretching exercises and local application of the heat. His neurological examination is normal and I do not expect any structural abnormality of the brain.

[162] As noted above, Dr. Rehman examined the Appellant on two subsequent occasions and revised this opinion. In his report, dated March 4, 2004, Dr. Rehman reviewed the MRI report and was most concerned about the cervical myelopathy. At that time, Dr. Rehman was unable to provide a definitive diagnosis with respect to the headaches; he stated: “I am not sure if the right frontal headaches are related to the cervical degenerative disease, as I mentioned above. It could be posttraumatic [*sic*] headaches or stress headaches, but I feel that the major concern and issue at hand is the cervical myelopathy.”

[163] Dr. Rehman examined the Appellant again on July 12, 2004. In his report of that date, Dr. Rehman noted that the neurological examination was normal. He stated: “I feel that he is suffering symptoms of transformed migraine.” In the three examinations, only the second mentions anything (“posttraumatic headaches”) that could refer to post-concussion syndrome.

[164] In his clinical note, dated January 29, 2004, Dr. Johnstone simply wrote “post concussion syndrome.” While the symptoms supporting this diagnosis were not listed, in a letter dated September 16, 2005, counsel for the Appellant requested Dr. Johnstone’s opinion as to whether the Appellant may have sustained post concussive syndrome as a result of the MVA. Dr. Johnstone answered as follows: “yes – subjective due to symptoms of parasympathetic nervous system irritation i.e. dizziness, eye tearing”.

²³ It was interpreted to be normal.

[165] The Appellant was seen by Dr. Nair on March 8, 2004. In his report of that date, Dr. Nair concluded that: “[m]ost of his arm paresthesia and imbalance is likely related to the central cord contusion. I think *[sic]* may spontaneously resolve but I am surprised it is six months and he still has the problem.” Dr. Nair also stated that: “...he seems to have a headache which could be a form of cluster headache. In this case this could be post traumatic.” In addition, Dr. Nair noted that he had not seen the MRI at this point but stated that he understood the edema to be mild. He recommended an assessment by a neurosurgeon to “...see if any intervention is needed.”

[166] Dr. Nair recorded that: “[*The Appellant*] does not think he blacked out but was dazed at the time of injury.” Prior to this, and in his Application for Benefits, the Appellant indicated that he did not lose consciousness after the MVA.

[167] In his report to SGI, dated September 29, 2004, Dr. Endsing addressed the vestibular concussive syndrome diagnosed by Dr. Pillay, which will be discussed further below. However, as these comments may also be applicable to a post-concussion syndrome diagnosis as well, we will also address them here. Dr. Endsing stated that:

Lastly, regarding the suggestion of a vestibular concussive syndrome mentioned by Dr. Pillay in his letter of June 17, 2004, on review of the photographs showing the damage to the vehicle he was in it is my opinion this appears to be a low impact collision with minimal damage to the vehicle. The vehicle that hit him was a small car ([Volkswagen]) relative to the van that he was in. The symptom manifestation does not appear to be consistent with the low impact collision evidenced by the photographs. In any case the degenerative changes noted on x-rays of the cervical spine can not be accounted for by the collision. I think that statistics supplied through vehicle accident reconstruction would indicate that the probably *[sic]* of injury, given the nature of this accident, would be fairly minimal.

It is my opinion that his persistent symptoms are likely attributable to the degenerative changes that pre-dated his motor vehicle accident and may also be related to his past occupational history.

[Emphasis added]

[168] At the hearing, Dr. Endsing acknowledged that he was not an expert in the field of assessing whether a collision is low-impact in nature and determining the potential for injury and, therefore, he was not qualified to opine as to whether the Appellant was injured as a result of the forces involved in the MVA. We agree and, as a result, we would not place any reliance on this portion of his report.

[169] Dr. Agrawal saw the Appellant on December 31, 2004. At that time, the Appellant was concerned about the intermittent numbness in his arm, difficulty with balance, blurred vision, fatigue and headaches, which he stated that he suffered from seven to ten days a month. In his

report of that date, Dr. Agrawal noted normal gait, speech, and hearing. He also reported that the Appellant's knowledge, recent and remote memory and concentration were all normal. Dr. Agrawal stated that: "[h]e has not had any specific treatment and his MRI of the neck and MRI of the brain was reported as normal."²⁴ Dr. Agrawal concluded as follows: "I think his symptoms could be related to post-concussion syndrome. Given imaging studies has [*sic*] been normal, I do not think that we need to do anything further at this time. If he has not had any B12, folate and TSH screening, he can be sent for those tests." Dr. Agrawal also recommended a trial dose of Effexor as it "...can help his post-concussion symptoms, including mild depression and headache."

[170] We have a number of concerns regarding Dr. Agrawal's report. His diagnosis is tentative and the objective findings, which form the basis for his diagnosis, are not outlined in the report. Further, we note that Dr. Agrawal first examined the Appellant almost one year and one-half after the MVA. Moreover, we question why the MRI of the neck was reported as "normal." Given the severe degenerative disc disease noted on the MRI, we question whether Dr. Agrawal reviewed a copy of the MRI report. We are hesitant to place reliance on his diagnosis in the absence of any reference to the degenerative disc disease.

[171] In the Admissions Report, dated January 19, 2005, Ms. Welsh identified the Appellant's physiotherapy/massage therapy diagnosis as: "MVA with closed head injury, central nervous system injury, WAD II CSP, jaw, shldr, myofascial pain." She recorded his injury type as chronic: posture, muscle imbalance and closed head injury – post-concussion syndrome.

[172] Her conclusions were quite tentative:

I **believe** [the Appellant] demonstrates symptoms **similar** to post concussion **likely** due to the MVA. His disequilibrium **seems** related to cervical facet joint receptor disturbance and **possibly** a closed head injury. Altered body temperature and night sweats, fatigue, poor memory, heat in his head, blurred vision and severe headaches are all part of this.

[Emphasis added]

[173] Ms. Welsh outlined a treatment plan for the Appellant.²⁵ We question whether acupuncture and physiotherapy constitute the appropriate treatment for post-concussion syndrome and/or a closed head injury in the event that the Appellant indeed suffered this condition. None of the medical reports on the appeal file recommended these treatments. Thus,

²⁴ This is a curious statement given the MRI finding of severe degenerative disc disease at C5-6 and C6-7 with mild central cord edema at the C6-7 level and severe bilateral neural foraminal stenosis at both of these levels.

we have no evidence before us, other than Ms. Welsh's report and the subjective report of the Appellant, who testified that these treatments help him,²⁶ to establish that the treatments contribute to the Appellant's rehabilitation, lessen any disability arising from post-concussion syndrome caused by the MVA, or facilitate his recovery from the MVA. Furthermore, in the absence of the recommendation of treatment by one of the Appellant's physicians, there is no evidence upon which we can conclude that these treatments are necessary or advisable.

[174] The most recent examination of the Appellant by a neurologist was that of Dr. Nair on March 21, 2005. Dr. Nair had examined the Appellant before and did not mention post-concussion syndrome in his report. In his report, dated March 21, 2005, Dr. Nair noted that at that time, the Appellant advised that the numbness and tingling in his arm was better, that his headaches had improved and that his primary complaints were poor balance, blurry and watery vision, as well as poor memory and concentration. Dr. Nair stated, in his report, that: "[a]ll of his symptoms have started after he was in a motor vehicle accident in 2003." Dr. Nair further noted that: "I will arrange for him to have an ultrasound of the carotid because of the sudden loss of vision he is complaining about without headache on the right side." Dr. Nair suggested that the Appellant do walking exercises or Tai Chi to improve the "post traumatic imbalance." Dr. Nair referred him to Dr. Landry for a cognitive assessment "...because apparently his memory and concentration are major problems which is *[sic]* interfering with his work." Dr. Nair also noted that the nerve conduction and EMG studies done on the Appellant's right arm failed to show any peripheral neuropathy, radiculopathy or plexopathy.

[175] On April 10, 2005, Dr. Surtie submitted a report to counsel for the Appellant. He noted that he first saw the Appellant on July 24, 2003 and that he had seen him on a monthly basis ever since. Dr. Surtie stated as follows:

[The Appellant] was well before the accident, and subsequent to the accident he developed various symptoms related to the accident. He experienced headaches, which he describes as pulling of the right eye, poor balance, inability to shower with his eyes closed, difficulty in concentrating, loss of memory, numbness down the right arm and requires long periods of rest before he is able to move around. Watching TV, bright lights and noise bother him, as does welding, which *[sic]* did for a living. He also experiences ringing in the ears, feels fatigue and tired, and loss of balance to such an extent that he is unable to use a tractor or farm equipment.

....

²⁵See above at paragraph 89.

²⁶The Appellant testified that Ms. Welsh identified and helped his shoulder injury. The issue of the shoulder injury was not pursued further at the hearing.

[The Appellant] continues to have ongoing symptoms, which he finds very distressing, and affect his ability to participate in his normal activities such as farming, welding and, as [the Appellant] says “when the grand children come over, the running and noise bothers him.”

I am of the opinion, based on the continuing nature of the symptoms he is experiencing that he needs of *[sic]* continuing care. It is probable that he has TMJ as a result of the accident as he had no symptoms prior to the accident, and the accident exacerbated his degenerative disc disease in his neck.

[176] We note that Dr. Surtie does not mention the diagnosis of post concussion syndrome in this report, although he had earlier.²⁷

[177] As discussed above, Dr. Endsln, in his May 10, 2005 report to SGI, suggested that many of the Appellant’s neurological problems were attributable to the degenerative disc disease.

[178] Following his review of the most recent medical reports, Dr. Endsln concluded that his opinion of September 29, 2004 was unchanged because:

...all of the subsequent new practitioners that have been consulted most recently have based their opinion on history rather than objective assessment at the time or immediately after the motor vehicle accident. I think that the findings that have greatest validity and relevance in this case are those of the clinicians that assessed the claimant at the time of the motor vehicle accident and immediately following. It is my opinion that when subsequent caregivers automatically relate their findings that are based on a history only, to a motor vehicle accident years prior to without having assessed the individual at that time of the incident makes these opinions less credible in assigning causation. This does not mean that the claimant does not have the symptoms as stated but rather I do not believe these symptoms can be accurately connected to the motor vehicle accident....

[179] In his testimony, Dr. Endsln indicated that he accepted Dr. Lwanga’s differential diagnoses but stated that Dr. Lwanga was not the best person to make a diagnosis of post-concussion syndrome because he is a specialist in internal medicine. Dr. Endsln was of the view that a neurologist would be in a better position to make such a diagnosis. In this regard, he stated that he preferred Dr. Shawush’s opinion as he was the first neurologist to see the Appellant following the MVA. We note that Dr. Shawush did not provide a diagnosis of post-concussion syndrome in his report.

[180] Dr. Endsln indicated that he was not sure what Dr. Rehman meant by his diagnosis of “transformed migraine.” Dr. Endsln also disagreed that migraines are a symptom of post-concussion syndrome. He stated that migraines are usually vascular problems and are not associated with trauma.

[181] Dr. Endsln noted that Dr. Agrawal examined the Appellant for the first time almost one and one-half years after the MVA and, while Dr. Agrawal is a neurologist, Dr. Endsln was of the belief that Dr. Agrawal based his diagnosis purely on the Appellant’s subjective history

rather than objective physical findings. As noted above, Dr. Agrawal did not appear to examine the MRI report of the cervical spine and it is not clear what reports and information Dr. Agrawal reviewed prior to writing his report.

[182] Dr. Endsinn testified that he generally places less weight on the later reports of symptomatology because these reports often do not reflect the normal course or sequence that one would normally see with respect to injuries caused by a motor vehicle accident. Dr. Endsinn was of the view that most pathology manifests itself very quickly after trauma. He indicated that it is difficult to attribute causation when some symptoms have been reported many months after the MVA, as opposed to weeks later.

[183] Dr. Endsinn stated that, in his opinion, symptoms of post-concussion syndrome would include memory deficits, impaired judgment and headaches; he was of the view that it would be unusual for balance problems to be related to this diagnosis.

[184] Dr. Endsinn admitted, however, that the diagnosis of post-concussion syndrome was properly part of the differential diagnosis in this case. Dr. Endsinn acceded that it was possible that the Appellant may have had post-concussion syndrome, but he questioned the length of time that symptoms have persisted.

[185] On re-examination, however, Dr. Endsinn asserted that the constellation of symptoms reported by the Appellant could be accounted for by a number of other medical conditions. For example, he stated that eye tearing is not indicative of musculoskeletal injury; it could be related to headaches or form part of a migraine process. He noted that with the vascular process involved in an acute migraine, one can get other physical symptoms as well, such as dizziness and memory problems. These symptoms could manifest with respect to cluster headaches that have a migraine component as well. In addition, Dr. Endsinn noted that high blood pressure without regulation may also result in problems with memory, light-headedness or dizziness.²⁸ As noted above, Dr. Endsinn stated that some of the neurological symptoms experienced by the Appellant may also be related to the effects of the degenerative disc disease.

²⁷See paragraphs 156 and 157.

²⁸We note that both Dr. Pillay and Dr. Ogrady indicated that the Appellant was not hypertensive. However, Dr. Lwanga and Dr. Nair were of the view that he was mildly hypertensive. In Dr. Gherasim's Patient History form, dated July 15, 2004, the Appellant reported that he had used a 24-hour blood pressure monitor. He reported high blood pressure in the Welsh & Associates Admissions Report, dated January 12, 2005. At the hearing, the Appellant testified that his blood pressure was on the higher side of normal, but that he was not taking medication to control it. He also noted that he had gained approximately thirty pounds following the MVA and that he had subsequently lost the weight.

[186] In our view, however, Dr. Endsins's opinion does not adequately address the opinions of Dr. Nair. As noted above, on September 12, 2005, Dr. Nair was contacted by counsel for SGI and a letter was sent to him confirming their telephone conversation. Dr. Nair indicated that he could not identify any physical findings attributable to or causing the Appellant's current physical complaints, in particular dizziness and imbalance. At that time he had not identified any cognitive problems and had recommended an assessment by Dr. Landry. In addition, Dr. Nair agreed that the Appellant's condition remained essentially undiagnosed.

[187] Subsequently, Dr. Nair sent correspondence to SGI which indicated that he overlooked two points. He stated as follows:

I have seen this gentleman in March 2004. When he had Neurological deficits with tingling and loss of some sensation in the right arm. He also had imbalance. I attributed this to the swelling (showing he likely had an injury to the spinal cord in the neck). I expected this to get better, but suggested neurosurgical consult. When I saw him on March 21, 2005, he had only imbalance but his numbness had improved. **His main complaint was memory problem and unsteadiness which I could not detect. He also complained about episodes of loss of vision for which I arranged ultrasound test of brain circulation. Also I have not received Neuropsychologist's opinion.**

I need these reports to say I have not detected any problem related to the accident.

[Emphasis added]

[188] We agree. If Dr. Nair is of the view that he is not in a position to conclude that he has not "detected any problem" related to the MVA, we are certainly not in a better position to do so.

[189] We agree with Dr. Nair that a neuropsychological assessment is about the only way to determine whether the Appellant has the memory deficits, impaired judgment, and headaches that Dr. Endsins associates with post-concussion syndrome. We have taken into account that the early reports after the accident do not show "cerebral concussion or contusion as documented by health-care practitioner in first 48 hours", required for a permanent impairment assessment award.²⁹

[190] We have found the confusion and inconsistencies of the accumulated medical evidence unhelpful and we are unable to conclude that SGI's decision letter of October 7, 2004 is correct that the Appellant's "persistent symptoms are likely attributed to the degenerative changes that pre-date this motor vehicle accident and may also be related to *[his]* past occupational history." To the extent that this sentence applies to post-concussion syndrome (or perhaps vestibular

²⁹Appendix B, Schedule of Permanent Impairments, Division 2, Central and Peripheral Nervous System, Subdivision 1: Skull, Brain and Carotid Vessels, Part 1: Alteration of Brain Tissue or Function, 1.1 Cerebral Concussion or contusion as documented

concussive syndrome), we order that the decision of SGI denying treatment benefits and associated expenses for these conditions be set aside.

Memory Loss and Difficulty with Concentration

[191] Difficulty with concentration was first noted in Dr. Rehman's report, dated December 2, 2003. In his report of that date, Dr. Rehman noted that the Appellant did not lose consciousness or hit his head. Dr. Rehman stated that:

This patient seems to be suffering from stress headache. I do not feel that these are migraines. He has improved markedly. **Concentration problems and mild balance problems are sometimes associated with stress headache and I feel that after the headache is improved the rest of the symptoms would also be better in the next few months.** I have encouraged him to return back to work and to participate in daily activities even though he does not feel 100% okay. I briefed him about stretching exercises and local application of the heat. His neurological examination is normal and I do not expect any structural abnormality of the brain.

[Emphasis added]

[192] As noted earlier, Dr. Rehman subsequently amended his opinion regarding the nature of the headaches. In his March 4, 2004 report, he considered that the headaches could be stress headaches, post-traumatic headaches or related to the cervical degenerative disease. Then, in his July 14, 2004 report, Dr. Rehman stated that: "I feel that he is suffering symptoms of transformed migraine."

[193] Dr. Surtie recorded short-term memory loss in his clinical note for December 4, 2003.

[194] In his December 31, 2004 report, Dr. Agrawal stated that the Appellant's recent and remote memory and his concentration were normal. He also noted that the MRI of the neck and brain were reported as normal.³⁰ Dr. Agrawal concluded that: "I think his symptoms could be related to post-concussion syndrome. Given imaging studies has *[sic]* been normal, I do not think that we need to do anything further at this time." Dr. Agrawal also recommended a trial dose of Effexor as it "...can help his post-concussion symptoms, including mild depression and headache."

[195] In his March 21, 2005 report, Dr. Nair noted that the Appellant had returned to his office to investigate his "two main problems" of poor cognitive dysfunction and imbalance. Dr. Nair

by health-care practitioner in first 48 hours, (d) Post concussion syndrome, see Parts 4.6, 4.7 and 4.8. [These Parts deal with Communication Disorders, Alterations of Consciousness, and Cognitive function.]

³⁰As noted earlier, it appears that Dr. Agrawal did not review a copy of the MRI reports as the MRI of the Appellant's neck indicated severe degenerative disc disease at C5-6 and C6-7, with mild central cord edema at the C6-7 level as a result of the cord compression caused by the degenerative changes, as well as severe bilateral neural foraminal stenosis at both levels.

stated that: “[a]ll of his symptoms have started after he was in a motor vehicle accident in 2003.” The physical examination revealed no neck stiffness, normal funduscopy and visual fields, no heel to knee ataxia, no finger to nose ataxia, but a slow and jerky gait with some missteps. Dr. Nair asserted that he did not perform cognitive testing at that time as “...he discussed most of his problems with me.” Dr. Nair also noted that the MRI of the head failed to show any abnormality. Dr. Nair recommended an assessment by Dr. Landry regarding the concentration and memory problems, which the Appellant noted were “major problems” and were interfering with his work.

[196] In her report of January 19, 2005, Ms. Welsh concluded as follows:

I believe [the Appellant] demonstrates symptoms similar to post concussion likely due to the MVA. His disequilibrium seems related to cervical facet joint receptor disturbance and possibly a closed head injury. Altered body temperature and night sweats, fatigue, poor memory, heat in his head, blurred vision and severe headaches are all part of this.

[Emphasis added]

[197] In assenting to the contents of SGI’s September 12, 2005 correspondence, Dr. Nair indicated that he could not identify any physical findings attributable to or causing the Appellant’s current physical complaints. In addition, Dr. Nair agreed that the Appellant’s condition remained essentially undiagnosed. However, on September 15, 2005, Dr. Nair stated as follows:

When I was talking to you and signed the report, I over looked two points. I have seen this gentleman in March 2004. When he had Neurological deficits with tingling and loss of some sensation in the right arm. He also had imbalance. I attributed this to the swelling (showing he likely had an injury to the spinal cord in the neck). I expected this to get better, but suggested neurosurgical consult. When I saw him on March 21, 2005 he had only imbalance but his numbness had improved. **His main complaint was memory problem [sic] and unsteadiness which I could not detect.** He also complained about episodes of loss of vision for which I arranged ultrasound test of brain circulation. Also I have not received Neuropsychologist’s opinion.

I need these reports to say I have not detected any problem related to the accident.

[Emphasis added]

[198] The Appellant testified that he did not have any significant problems with memory prior to the MVA. He stated that he may have forgotten names, but not numbers. Following the MVA, he experienced difficulties with both dates and numbers.

[199] When asked, the Appellant said that he experienced memory problems right after the MVA, however, this was not noted on the Application for Benefits. Based on our review of the appeal file, difficulty with concentration was first noted in Dr. Rehman’s December 2003 report and short-term memory loss was first noted in Dr. Surtie’s December 4, 2003 clinical note.

[200] The Appellant stated that his memory is better now than it was after the MVA and that he is slowly getting better.

[201] The Appellant testified that he was not sure if his memory problems were a result of the MVA or as a result of some of the medications he took. He jokingly noted that his age was not helping him either.

[202] We note that no treatment has been recommended for memory loss or difficulty with concentration in isolation. Indeed, at this time, there is no objective medical information on the appeal file to substantiate the Appellant's subjective complaints. The neuropsychological assessment would provide an objective evaluation of the Appellant's cognitive complaints. Therefore, we order that this assessment be performed at SGI's expense and be provided to Dr. Nair for his further report.

Loss of Balance, Lack of Co-ordination and Dizziness

[203] The Appellant was seen and treated for a constellation of symptoms relating to his ears and balance.

[204] The Appellant listed lack of balance to be one of his most severe injuries in the Application for Benefits. It was certainly the first in time.

[205] The Appellant reported a loss of balance to Dr. Surtie on July 24, 2003.

[206] In his report, dated August 1, 2003, Dr. Shawush noted that the Appellant had problems with his balance but stated that: "[o]verall his symptoms are improving." Dr. Shawush found nothing remarkable in the physical examination and stated that there was no evidence of radiculopathy or neuropathy. He indicated that there was no need for any further neurological investigation and provided a diagnosis of mild whiplash injury.

[207] On September 22, 2003, Dr. Lwanga noted that the Appellant's gait, co-ordination and speech were normal.

[208] On December 2, 2003, Dr. Rehman's physical examination revealed normal co-ordination and gait. He concluded that: "[c]oncentration problems and mild balance problems are sometimes associated with stress headache and I feel that after the headache is improved the

rest of the symptoms would also be better in the next few months.... His neurological examination is normal and I do not expect any structural abnormality of the brain.”

[209] The Appellant discussed “lightheadedness” with otolaryngologist, Dr. Ogrady in January 2004 and March 2004. He did not report any “sensation of rotation or movement of either himself or the environment.” He reported that the dizziness would last for up to several hours, and was often relieved by sleep. Dr. Ogrady performed full otolaryngologic examinations on three occasions: they were “completely unremarkable”. Dr. Ogrady thought the “vertigo [*does*] not sound particularly labyrinthine in its origin,” and amplified this in a later report: “[h]is dizziness...does not sound like benign paroxysmal positional vertigo.”

[210] The Appellant then attended the offices of Dr. Pillay, also an otolaryngologist, in June 2004, complaining of dizziness, loss of balance, tinnitus and diminished hearing on one side. The Appellant reported dizziness when he watched TV; he required long periods of rest before being able to move around; and that he could not shower with his eyes closed. Dr. Pillay recorded that his responses were generally slow, cerebellar tests revealed ataxia and he could not complete the Romberg test.³¹ Dr. Pillay offered a diagnosis of post-MVA vestibular concussion and neck injury, as well as possible hearing loss. He endorsed the plan for an MRI head scan.

[211] The Appellant has been seen by four neurologists. None of them have documented ataxia.

[212] In August, 2003, he reported mild nausea and balance problems to Dr. Shawush. At that time his “general physical exam [*was*] unremarkable. He [*was*] neurologically intact”.

[213] In his report, dated March 4, 2004, Dr. Rehman observed that his coordination and gait was normal. When the Appellant’s wife stated that the ataxia on turning was his main reason for not being able to work, Dr. Rehman checked the Appellant’s gait again and noted “mild trouble” walking in a straight line.

[214] Dr. Nair, in his report dated March 8, 2004, stated that: “[h]e has a slightly slow gait but true ataxia is not shown.” He thought the imbalance was likely related to the central cord contusion.

³¹related to ataxia.

[215] Dr. Rehman mentioned balance problems again in July 2004, but the focus of the investigation was on vision.

[216] In his physical examination March, 2005, Dr. Nair noted no heel to knee ataxia, no finger to nose ataxia, and a slow and jerky gait with some missteps. Dr. Nair also noted that the MRI of the head failed to show any abnormality.

[217] Aside from improving his balance through physical exercise or Tai Chi, as recommended by Dr. Nair, there are no treatments recommended for his loss of balance, lack of co-ordination and dizziness.³²

[218] In his report to SGI, dated September 29, 2004, Dr. Endsinn stated that:

Lastly, regarding the suggestion of a vestibular concussive syndrome mentioned by Dr. Pillay in his letter of June 17, 2004, on review of the photographs showing the damage to the vehicle he was in it is my opinion this appears to be a low impact collision with minimal damage to the vehicle. The vehicle that hit him was a small car ([Volkswagen]) relative to the van that he was in. The symptom manifestation does not appear to be consistent with the low impact collision evidenced by the photographs. In any case the degenerative changes noted on x-rays of the cervical spine can not be accounted for by the collision. I think that statistics supplied through vehicle accident reconstruction would indicate that the probably [*sic*] of injury, given the nature of this accident, would be fairly minimal.

It is my opinion that his persistent symptoms are likely attributable to the degenerative changes that pre-dated his motor vehicle accident and may also be related to his past occupational history.

[Emphasis added]

[219] At the hearing, Dr. Endsinn acknowledged that he was not an expert in the field of assessing whether a collision is low-impact in nature and determining the potential for injury and, therefore, he was not qualified to opine as to whether the Appellant was injured as a result of the forces involved in the MVA. We agree and, as a result, we would not place any reliance on this portion of his report.

[220] Dr. Endsinn also acknowledged at the hearing that he accepted Dr. Pillay's findings on examination and his diagnosis within his area of expertise i.e. ears, nose and throat, but that he has difficulty accepting the diagnosis of vestibular concussive syndrome given that Dr. Pillay's area of expertise is otolaryngology. Dr. Endsinn also noted that he cannot accept Dr. Pillay's attribution of the Appellant's symptoms to the MVA, especially when Dr. Pillay did not examine the Appellant following the MVA and the doctors that did examine him did not make similar findings or diagnoses. Dr. Endsinn was of the view that Dr. Pillay's opinion on causation

³²We note that Ms. Welsh's treatment plan included gait re-education and balance training, but it does not appear from the evidence before us that these treatments were actually provided.

was based on the Appellant's subjective history and should not be accepted. In addition, Dr. Endsins stated that he would attribute less weight to Dr. Pillay's opinion than Dr. Ogrady's since Dr. Pillay did not see the Appellant until June 2004.

[221] Dr. Endsins was of the view that Dr. Pillay was not in the best position to offer an opinion as to causation because he likely did not review the Appellant's entire medical file. Dr. Endsins indicated that, in his experience, most specialists only have the referral letter from the doctor, which may or may not include a summary of findings and investigations. It is not clear what reports and information Dr. Pillay reviewed prior to making his diagnosis. Dr. Endsins did acknowledge, however, that Dr. Pillay was required to satisfy himself before making his diagnosis, as are all doctors.

[222] As outlined above, based on the evidence before us, and, especially given the absence of any reference in Dr. Pillay's report to the degenerative disc disease, we are inclined to discount the vestibular concussion diagnosis. We prefer the opinions of the neurologists outlined above, who did observe some unsteadiness, but not ataxia, and the repeated findings of neurological normality, as well as Dr. Ogrady's repeated findings of otolaryngological normality. We think Dr. Endsins's points in the two preceding paragraphs are valid.

[223] The Appellant may well object, "Yes, but I still get dizzy and have trouble walking." These symptoms may be, as suggested by Dr. Nair, attributable to the central cord swelling. The Appellant is, of course, at liberty to continue to search for a diagnosis and appropriate treatment.

[224] In light of the investigations to date, however, we do not think that SGI's decision on this issue was wrong. It has arranged for detailed investigation of the problem, and we do not fault its conclusion.

Tinnitus and Hearing Loss

[225] In his report, dated January 30, 2004, Dr. Ogrady noted that the Appellant stated that he was experiencing tinnitus which was "intermittent, high pitched, bilateral and constant," but that he had not noticed a change in hearing since the MVA. A full otolaryngologic examination was performed and the results were "completely unremarkable." In his consult summary, Dr. Ogrady stated that: "I have made arrangements for an audiogram and brainstem evoked

response audiogram but I doubt that this is related to that incident....and unless something shows up on the evaluation, no further investigation would be warranted.”

[226] Dr. Ogrady examined the Appellant again on April 8, 2004. In his report of that date, Dr. Ogrady noted that the Appellant reported the onset of some tinnitus associated with the use of Ibuprofen, but that there was a minimal change in the tinnitus once the Ibuprofen was stopped. Dr. Ogrady again noted that a full otolaryngologic examination was performed and the results were essentially normal. However, the audiogram results were interpreted as abnormal³³ and, as a result, the Appellant was placed on the waiting list for an MRI.

[227] On April 30, 2004, the Appellant had a follow-up appointment with Dr. Ogrady. In his report of that date, Dr. Ogrady noted that the Appellant had noticed errors in his April 8, 2004 report. The Appellant advised that he developed headaches within a few hours of the MVA and that his age was incorrectly recorded. At this visit, the Appellant also reported some eustachian tube dysfunction. Dr. Ogrady again performed a physical examination and noted that it was unremarkable. He concluded that:

This man continues to have ongoing symptomatology which he finds very distressing. At the present time, the abnormal results that need further investigation include the audiogram and brainstem evoked response audiogram. **Physical examination fails to reveal any obvious abnormalities. His concern over the recent onset of tinnitus is likely related to his fairly significant noise induced hearing loss.**

[Emphasis added]

[228] The Appellant then attended the offices of Dr. Pillay, otolaryngologist, for complaints of tinnitus, dizziness, loss of balance and diminished hearing on one side. In his report of June 1, 2004, Dr. Pillay recorded that the Appellant may have had mild hearing loss prior to the MVA, but that he [the Appellant] is uncertain about this. Dr. Pillay stated that the Appellant attributed some of the tinnitus to the period when he was taking Naprosyn, Amitriptyline and Diazepam following the MVA. He stated that a review of the audiometric assessment needed to be performed, however, he also noted that the Appellant had already been fully assessed and was waiting for the MRI. Dr. Pillay also recommended that Dr. Surtie review the MRI report and consider follow up of the patient by the Rehabilitation Clinic. It is not clear what Dr. Pillay meant by a” follow up” by the Rehabilitation Clinic, however, we note that no specific treatment was identified.

³³ Audiograms, including brainstem evoked audiograms, we understand, measure hearing or hearing loss.

[229] In summary, while Dr. Pillay was more interested in the vestibular concussion, he had no information available on hearing loss at the time of his report, and described the Appellant's history of the medication-associated tinnitus as "vague".

[230] Based on the evidence before us, we are of the view that tinnitus was not reported by the Appellant until after he started taking medication and that hearing loss was apparently not reported until January 2004.

[231] The Appellant testified that one of the medications that he was taking may have caused the ringing in his ears but that he was told that he did not take enough of it for that to happen. However, the Appellant also testified that initially he took a lot of the Ibuprofen-based medication immediately following the MVA in order to finish harvesting and that he forgot when he took it and how much he had taken. He could not recall when he first noticed the tinnitus.

[232] Treatment has not been recommended either for tinnitus or hearing loss. We note that a letter to Dr. Endsinn from Ms. Sparrowhawk, dated September 24, 2004, indicated that the Appellant was scheduled to get hearing aids but turned this down to see if TMJ treatment would help instead.³⁴

[233] As previously stated in connection with the imbalance and dizziness, while the Appellant may continue to pursue an investigation of the tinnitus problem, we are satisfied that Dr. Ogrady's opinion that it is related to his substantial noise-induced hearing loss (not related to the motor vehicle accident) justifies SGI's decision with respect to this problem.

TMJ

[234] The decision letter, dated October 7, 2004, specifically denied responsibility for TMJ symptoms and treatment on the grounds that symptoms were not documented until many months after the MVA and, therefore, were unrelated to the MVA.

[235] At the hearing, Dr. Endsinn explained that TMJ symptoms usually manifest themselves fairly quickly after a trauma.

³⁴ This was not addressed at the hearing.

[236] Dr. Endsins stated that he had problems associating Dr. Gherasim's opinion with the lack of TMJ findings immediately after MVA. Dr. Endsins indicated that he would prefer to see a "trail of symptoms" from the date of the MVA right up to the date of diagnosis.

[237] Dr. Endsins was of the opinion that Dr. Gherasim relied primarily on the Appellant's subjective reporting as the basis for his diagnosis, as opposed to objective findings. Dr. Endsins believed that Dr. Gherasim's opinion on causation was simply based on the subjective history of the Appellant.

[238] However, Dr. Endsins acknowledged Dr. Gherasim's expertise in the area and recognized his opinion and competency. Dr. Endsins also admitted that the Appellant suffered from headaches following the MVA and that headaches are one of many symptoms of TMJ. Dr. Endsins agreed that there was no evidence that the Appellant experienced headaches from October 17, 2001 until after the MVA.

[239] We note that Dr. Johnstone's clinical notes for September 2, 2003 include a notation indicating right TMJ symptoms. This is less than two months after the MVA. We further note that Dr. Johnstone indicated that he treated the Appellant for TMJ dysfunction following August 15, 2003.

[240] The Appellant completed a comprehensive Patient History for Dr. Gherasim on July 15, 2004 and on September 12, 2004, Dr. Gherasim requested phase I and II TMJ treatment for the Appellant due to whiplash trauma.

[241] As stated above, in the Admissions Report, dated January 19, 2005, Ms. Welsh noted TMJ findings on examination and outlined a treatment plan for the Appellant involving treatments twice a week for 8-10 sessions. However, for the reasons outlined previously, it is not clear whether the treatment provided was directed at treating the TMJ symptoms.

[242] In his April 10, 2005, Dr. Surtie concluded as follows:

I am of the opinion, based on the continuing nature of the symptoms he is experiencing that he needs of *[sic]* continuing care. **It is probable that he has TMJ as a result of the accident as he had no symptoms prior to the accident**, and the accident exacerbated his degenerative disc disease in his neck.

[Emphasis added]

[243] At the hearing, Dr. Endsins stated that he does not accept this conclusion and questioned why Dr. Surtie did not include TMJ as a diagnosis in any of his earlier reports.

[244] As noted above, Dr. Johnstone's clinical notes indicate that there was evidence of TMJ symptoms less than two months after the MVA and that Dr. Johnstone treated the Appellant for TMJ symptoms following the MVA. Further, Dr. Gherasim requested Phase I and Phase II treatment for the Appellant's TMJ symptoms that he linked to the MVA. Moreover, there is no evidence of TMJ-related symptoms prior to the MVA; the evidence indicates that the Appellant did not seek treatment for headaches from October 17, 2001 until after the MVA. In light of this, we find that the Appellant suffered from TMJ symptoms as a result of the MVA. As a result, the decision letter, dated October 7, 2004, denying SGI's responsibility for TMJ symptoms and the funding of TMJ treatment is set aside as it was based on the erroneous assumption that "...these symptoms were not mentioned or documented until many months after the accident and therefore would be unrelated."

[245] As outlined above, it is not clear from Ms. Welsh's report whether the treatments provided were directed at treating the Appellant's TMJ symptoms. In the absence of a recommendation for this treatment by Dr. Nicholson's physicians, we are unable to conclude that the treatments provided by Ms. Welsh were necessary or advisable or that these treatments contributed to the Appellant's rehabilitation, facilitated his recovery or lessened his disability. We are of the view, however, that the appropriate treatment is that identified by Dr. Gherasim.

Visual Disturbances

[246] In the Application for Benefits, the Appellant recorded that the sight in his right eye was one of his most severe injuries. He testified that it was weeping and that he had blurred vision following the MVA. He also stated that he mentioned this to Dr. Rose the day of the MVA, but that Dr. Rose did not record this in his clinical notes.

[247] The Appellant stated that following the MVA he could not watch TV for more than one hour or so. He had to pace himself at work because if he did not, his vision became blurred and he would have a headache. The Appellant indicated that following the MVA, he would have a headache before the vision problems commenced, but now the headaches follow the vision difficulties. He testified that he cannot drive into the sun and he cannot drive at night. The Appellant stated that "eye motion" bothers him; he is able to do manual labour, but the motion of combining, for example, appears to trigger the visual difficulties.

[248] Occasional blurred vision was noted in the reports of Dr. Shawush, Dr. Lwanga, Dr. Surtie,³⁵ Dr. Rehman, Dr. Johnstone and Dr. Agrawal.

[249] On September 22, 2003, Dr. Lwanga noted that there was a slight drooping of the Appellant's left upper eyelid, but that his visual testing did not reveal any deficits.

[250] Dr. Surtie's clinical note for December 4, 2003 indicated that the Appellant reported twitching in his right eye when watching TV and from the early morning glare of the sun.

[251] On March 2, 2004, Dr. Surtie wrote to SGI that the Appellant had been complaining of a post-concussion headache, a painful right eye with blurring vision and a problem with his balance since the MVA.

[252] Dr. Pillay noted a droopy eyelid in his June 1, 2004 report.

[253] In his July 12, 2004 report, Dr. Rehman's observed that, on examination, the Appellant was severely photophobic and was unable to tolerate the light for the funduscope examination. However, Dr. Rehman stated that there was no ptosis.

[254] Dr. Johnstone indicated that he treated the Appellant for ocular symptoms of pain and photosensitivity following the MVA.

[255] Dr. Surtie's clinical note for March 14, 2005 includes a notation that: "...eyes droop and tear."

[256] In his report of March 21, 2005, Dr. Nair noted that the Appellant indicated that occasionally his vision went totally black in the right eye and that this was no longer followed by headaches. Dr. Nair's examination revealed normal funduscopy and visual fields. He arranged for an ultrasound of the carotid due to "...the sudden loss of vision he is complaining about without headache on the right side." The results of this test were not available at the date of the hearing. In the September 12, 2005 letter, Dr. Nair acknowledged that he could not identify any physical findings attributable to or causing the Appellant's current physical complaints. In addition, Dr. Nair agreed that the Appellant's condition remained essentially undiagnosed. On September 15, 2005, SGI received a further response from Dr. Nair indicating

³⁵ This also appears in Dr. Surtie's clinical notes.

that he overlooked two points when he agreed with the contents of the September 12, 2005 correspondence:

When I was talking to you and signed the report, I over looked two points...When I saw him on March 21, 2005 he had only imbalance but his numbness had improved. His main complaint was memory problem *[sic]* and unsteadiness which I could not detect. **He also complained about episodes of loss of vision for which I arranged ultrasound test of brain circulation. Also I have not received Neuropsychologist's opinion.**

I need these reports to say I have not detected any problem related to the accident.

[Emphasis added]

[257] We are unable to find any medical reports that recommend treatment for the Appellant's visual difficulties and there is no evidence before us to indicate that Dr. Johnstone treated the Appellant for ocular symptoms after August 25, 2004. However, we are aware that an ultrasound of the carotid was ordered by Dr. Nair in 2005. We order that this be reviewed, or, in the unlikely event that this has not been done, to be performed on an expedited basis and that the results be provided to Dr. Nair for his further report.

[258] We expect that at some point, the Appellant's eye problems must have been considered by an ophthalmologist. No such reports were filed. We have recommended that they be provided to Dr. Endsins as it may assist in the assessment outlined below.

Drowsiness and Fatigue

[259] Dr. Surtie's Practitioner's Report, dated October 27, 2003, based on the July 24, 2003 examination, noted that he prescribed massage therapy, Ibuprofen, Amitriptyline and Lorazepam. Dr. Surtie recorded that drowsiness due to medications and low-grade headaches were the medical reasons for the Appellant being unable to participate in normal activities, including work.

[260] Dr. Surtie's clinical note, dated October 27, 2003 stated: "...dizziness and drowsiness due to meds." This is consistent with Dr. Surtie's clinical note of November 13, 2003, in which he stated that the Appellant "...sleeps all the time." Dr. Lwanga noted this as well in his letter, dated January 2004, in which Dr. Lwanga stated that he decreased the amount of Elavil and Valium because the Appellant's wife advised that: "he can sleep all day!"

[261] On December 2, 2003, Dr. Rehman noted that the Appellant had taken Amitriptyline, Diazepam and Naprosyn and that these medications "...caused marked drowsiness."

[262] This was reiterated in Dr. Surtie's clinical note for June 28, 2004, which stated as follows: "...says medications make him lose his balance and cause severe drowsiness and tiredness."

[263] The Appellant testified that his fatigue is improving, but that when he was on the medications prescribed by Dr. Lwanga, he slept up to 20 hours per day. He stated that he required twelve hours of sleep per day to function without headaches.

[264] In our view, the Appellant's drowsiness and fatigue was largely due to the medication he was taking. In addition, we note that there are no recommendations for treatment with respect to the Appellant's fatigue and we refer to this issue for the convenience of Dr. Endsing as it may assist in his assessment, which is referred to below.

SUMMARY OF FINDINGS AND CONCLUSIONS

[265] With respect to the relationship between the Appellant's symptoms and the MVA, and his need for ongoing treatment as a result of the MVA, we have found:

- (1) **Neck pain:** The MVA aggravated the Appellant's degenerative disc disease. The acupuncture and physiotherapy treatments provided by Dr. Johnstone and Ms Welsh likely related to his neck pain, which flared up during a period that could be reasonably considered attributable to the original recovery. We order that the invoices submitted be reviewed by SGI on the basis that the treatments were necessary or advisable.³⁶
- (2) Since neck pain was not a problem for the Appellant at the time of the hearing two years after the MVA, we conclude that the exacerbation of his condition by the MVA is no longer a causative factor. He will likely continue to have neck pain on what we hope is no more than an occasional basis, but we are of the view that the role of the MVA in accelerating the degenerative disc disease has been accounted for.³⁷
- (3) **Numbness and tingling:** We conclude that the MVA did cause the numbness and occasional tingling, not experienced before. As with the neck pain, these

³⁶See paragraphs 105 to 107.

³⁷See paragraphs 105 to 107.

symptoms have resolved. We do not have any basis to believe that the Appellant requires further treatment, or that this constitutes a permanent impairment.³⁸

- (4) **Headaches:** The headaches, by themselves, have not been definitively diagnosed. However, they seem to be of declining importance. Given the equivocal nature of the medical evidence, we are unable to conclude, on the evidence before us, that SGI's decision letter of October 7, 2004 is correct that the Appellant's "persistent [*headache*] symptoms are likely attributed to the degenerative changes that pre-date this motor vehicle accident and may also be related to [*his*] past occupational history."³⁹ We order that this issue be considered as set out below.
- (5) **Post concussion syndrome:** We have found the confusion and inconsistencies of the accumulated medical evidence unhelpful and we are unable to conclude that SGI's decision letter of October 7, 2004 is correct that the Appellant's "persistent symptoms are likely attributed to the degenerative changes that pre-date this motor vehicle accident and may also be related to [*his*] past occupational history." We order that this issue be considered as set out below.⁴⁰
- (6) **Memory loss and concentration:** We note that no treatment has been recommended for memory loss or difficulty with concentration in isolation. Indeed, at this time, there is no objective medical information on the appeal file to substantiate the Appellant's subjective complaints. The neuropsychological assessment recommended would provide an objective evaluation of the Appellant's cognitive complaints, and may shed light on other complaints. Therefore, we order that this assessment be performed at SGI's expense and be provided to Dr. Nair for his further report.⁴¹
- (7) **Loss of Balance, Lack of Co-ordination and Dizziness:** These conditions have been sufficiently evaluated, in our opinion. The Appellant is, of course, at liberty to continue to search for a diagnosis and appropriate treatment.⁴² In light of the investigations to date, however, we do not think that SGI's decision on this issue

³⁸See paragraphs 118 and 119.

³⁹See paragraph 153.

⁴⁰See paragraphs 189 and 190.

⁴¹See paragraph 202.

⁴²See paragraph 224.

was wrong. It has arranged for detailed investigation of the problem, and we do not fault its conclusion.

- (8) **Tinnitus and Hearing Loss:** As previously stated in connection with the imbalance and dizziness, while the Appellant may continue to pursue an investigation of the tinnitus problem, we are satisfied that Dr. Ogrady's opinion that it is related to his substantial hearing loss (not related to the motor vehicle accident) justifies SGI's decision with respect to this problem.
- (9) **TMJ:** The portion of the decision letter, dated October 7, 2004, dealing with SGI's responsibility for TMJ symptoms and the funding of TMJ treatment is set aside on the grounds that it was based on the erroneous assumption that "...these symptoms were not mentioned or documented until many months after the accident and therefore would be unrelated." We are of the view that the appropriate treatment is that identified by Dr. Gherasim.⁴³
- (10) **Visual Disturbances:** We are unable to find any medical reports that recommend treatment for the Appellant's visual difficulties and there is no evidence before us to indicate that Dr. Johnstone treated the Appellant for ocular symptoms after August 25, 2004. We order that the ultrasound of the carotid ordered by Dr. Nair in 2005 be reviewed, or, in the unlikely event that this has not been done, to be performed on an expedited basis and that the results be provided to Dr. Nair for his further report.
- (11) We expect that at some point, the Appellant's eye problems must have been considered by an ophthalmologist. No such reports were filed. We recommend that they be obtained and provided to Dr. Endsinn.⁴⁴
- (12) **Drowsiness and Fatigue:** In our view, the Appellant's drowsiness and fatigue was largely due to the medication he was taking. In addition, we note that there are no recommendations for treatment with respect to the Appellant's fatigue and

⁴³See paragraphs 244 and 245.

⁴⁴See paragraphs 257 and 258.

we refer to this issue for the convenience of Dr. Endsinn as it may assist in his assessment.⁴⁵

[266] Given that the Appellant missed the appeal period, we do not have jurisdiction to review the termination of his IRB.

DETAILED ORDER

[267] The portion of the decision letter, dated October 7, 2004, dealing with SGI's responsibility for TMJ symptoms and the funding of TMJ treatment is set aside as it was based on the erroneous assumption that "...these symptoms were not mentioned or documented until many months after the accident and therefore would be unrelated." We are of the view that the appropriate treatment was identified by Dr. Gherasim.

[268] As a result of the findings we have made, we are unable to conclude that SGI's decision letter of October 7, 2004 is correct that the Appellant's "persistent symptoms are likely attributed to the degenerative changes that pre-date this motor vehicle accident and may also be related to *[his]* past occupational history." Therefore, we order that the decision of SGI denying a permanent impairment benefit, treatment benefits and associated expenses be set aside to the extent necessary to give effect to our findings.

[269] In the event that the neuropsychologist's assessment and the ultrasound test of brain circulation requested by Dr. Nair have not yet been performed, we specifically order that these be performed at SGI's expense and be provided to Dr. Nair for his further report.

[270] In addition, we order that the Appellant obtain an up-dated report on his general medical condition and, if he has not already been to an ophthalmologist, that he do so with respect to his vision problems. If there are any existing reports by an eye specialist, we order that these be forwarded to Dr. Endsinn for his further review.

[271] We specifically order that Dr. Endsinn's report consider all the up-dated medical information and re-address the diagnosis, causation and treatment of the Appellant's symptoms. If, in his opinion, the new information invalidates any of the findings we have made, he is, of course, free to say so.

⁴⁵See paragraph 264.

COSTS

[272] Counsel for the Appellant requested costs on a solicitor and client basis on the grounds that the hearing was necessitated by SGI's actions in denying or terminating benefits to the Appellant. He submitted that the only factor in determining costs should be success on appeal and that the only costs which can be intended in this appeal are solicitor and client costs. He also took the position that the Appellant should not be penalized by paying his own legal costs, which he incurred in order to protect his rights.

[273] In other cases before the Commission,⁴⁶ the argument that has been made is that the \$2,500 cap applies only with respect to "reasonable expenses" under subsection 193(11) of the Act and does not apply to legal costs. Subsection 193(12) of the Act is intended to address legal costs and, thus, is not subject to the cap.

[274] Subsection 193(11) of the Act states that a claimant, if successful on appeal, shall be reimbursed for the claimant's costs in the prescribed amount by the insurer. In our view, this provision must be read in conjunction with section 96 of *The Personal Injury Benefits Regulations*, c. A-35, Reg. 3, as amended (hereinafter the "Regulations"), which states that the insurer shall reimburse the claimant for all reasonable expenses. The maximum amount of all reasonable expenses is \$2,500. In our opinion, "reasonable expenses" includes legal costs on a party-party basis.⁴⁷ We are of the view that subsection 193(12) of the Act is a taxing provision.⁴⁸

[275] We have considered and rely on *Bear v. Saskatchewan Government Insurance*,⁴⁹ wherein Justice Ryan-Froslic found that the Act does not imply an automatic award of solicitor/client costs given that subsection 198(5) of the old Act, which provided for solicitor/client costs, was expressly repealed. In *Bear*, *supra*, Justice Ryan-Froslic cited the Saskatchewan Court of Appeal case of *Siemens v. Bawolin*.⁵⁰ In that case, the Court of Appeal outlined four principles to be applied in considering an award of solicitor and client costs:

1. solicitor and client costs are awarded in rare and exceptional cases only;
2. solicitor and client costs are awarded in cases where the conduct of the party against whom they are sought is described variously as scandalous, outrageous or reprehensible;

⁴⁶See also *K.A. v. SGI*, 2005 SKAIA 013 and *H.L. v. SGI*, 2005 SKAIA 007.

⁴⁷*Ibid.*

⁴⁸*Ibid.*

⁴⁹2004 SKQB 398.

⁵⁰219 Sask. R. 282 (CA).

3. solicitor and client costs are not generally awarded as a reaction to the conduct giving rise to the litigation, but are intended to censure behaviour related to the litigation alone;
4. notwithstanding point 3, solicitor and client costs may be awarded in exceptional cases to provide the other party complete indemnification for costs reasonably incurred.⁵¹

[276] Applying these factors to the case at hand, we are unable to find that SGI's denial of benefits constituted scandalous, outrageous or reprehensible conduct and we do not find SGI's conduct prior to or at the hearing to be scandalous, outrageous or reprehensible. We do not find any conduct on the part of SGI that should be censured, nor do we find any circumstance or conduct that would identify the case at hand as an exceptional one so as to warrant an award of solicitor/client costs. The request for solicitor client costs is, therefore, denied.

[277] Since the Appellant has been successful in part, he shall be entitled to all reasonable costs of the appeal, including travel expenses, meals, lodging, and legal costs on a party-party basis in accordance with column 3 of the Court of Queen's Bench Tariff of Costs. In accordance with the decision of the Commission in *N.N. v. Saskatchewan Government Insurance*,⁵² we allow the fee for hearing preparation, preparation of brief, and attendance at the hearing at double column three of the Tariff. The limitation set out in subsection 96(1) of the Regulations in the maximum amount of \$2,500 applies. The Appellant is also entitled to the reimbursement of his appeal fee in accordance with subsection 86(4) of the Regulations. He is also entitled to be reimbursed for the cost of the 2004 MRI Report and Dr. Surtie's April 10, 2005 Report in accordance with section 169 of the Act and subsection 76(1) of the Regulations. The Appellant is also entitled to reimbursement for the conduct money, process servers and subpoenas issued to Dr. Endsinn and Garth Cowling. While Ms. Sparrowhawk was eventually excused from testifying at the hearing for medical reasons, she was one of the Appellant's personal injury representatives and we are of the view that the Appellant is entitled to be reimbursed for service of the subpoena in the claimed amount of \$36.54.

Dated at Regina, Saskatchewan, on April 2, 2007.

⁵¹*Supra*, at para 118.

⁵²2004 SKAIA 005.

Ann Phillips, Q.C., Chair

Beverly Cleveland, Commission Member

Stephanie Pfefferle, Commission Member