Citation: ***E. P. v. Minister of Employment and Social Development*****, 2015 SSTGDIS 33**

Date: April 23, 2015

File number: GT-124288

GENERAL DIVISION- Income Security Section

Between:

E. P.

Appellant

and

Minister of Employment and Social Development
(formerly known as the Minister of Human Resources and Skills Development)

Respondent

Decision by: Neil Nawaz, Member, General Division – Income Security Section

Decided on the record, April 23, 2015

REASONS AND DECISION

PERSONS IN ATTENDANCE

Neither the Appellant nor any representative appeared at a videoconference hearing that had been scheduled for April 20, 2015.

DECISION

[1] The Social Security Tribunal (Tribunal) finds that a *Canada Pension Plan* (CPP) disability pension is not payable to the Appellant.

INTRODUCTION

[2] The Appellant's application for a CPP disability pension was date stamped by the Respondent on January 5, 2012. The Respondent denied the application initially and upon reconsideration. The Appellant appealed the reconsideration decision to the Office of the Commissioner of Review Tribunals (OCRT) and this appeal was transferred to the Tribunal in April 2013.

[3] In a Notice of Hearing dated January 7, 2015, this appeal was originally scheduled to be heard by videoconference for the following reasons:

- The form of hearing provided for the accommodations required by the parties or participants;
- The Appellant would have been the only party attending the hearing;
- Videoconferencing was available in the area where the Appellant lives;
- The issues under appeal were complex;
- There were gaps in the information in the file and/or a need for clarification;
- The form of hearing was the most appropriate to address inconsistencies in the evidence; and,

- The form of hearing respected the requirement under the Social Security Tribunal Regulations to proceed as informally and quickly as circumstances, fairness and natural justice permit.

[4] On April 10, 2015, the Appellant sent an email to the Tribunal requesting a postponement, saying she needed more time to submit information. She disclosed that she underwent a total knee replacement in May 2014 and had attempted to work in November 2014 but only managed to do so for 32 days. A second knee replacement was pending. In a letter dated April 14, 2015, the Tribunal refused this request, noting the Appellant had ample opportunity to request an adjournment earlier. Moreover, as the Appellant had taken an early CPP retirement pension in December 2011, the latest possible date of disability onset was November 30, 2011. In the Tribunal's view, additional medical information from 2014 and 2015 would have had only limited relevance.

[5] On April 14, 2015, the Appellant advised the Tribunal by telephone that she would not be attending the hearing. Based on the foregoing circumstances and having reviewed the hearing file, the Tribunal concluded that the Appellant's right to procedural fairness would not be prejudiced by proceeding in her absence by way of a hearing based on the documentary record.

THE LAW

[6] Section 257 of the *Jobs, Growth and Long-term Prosperity Act* of 2012 states that appeals filed with the OCRT before April 1, 2013 and not heard by the OCRT are deemed to have been filed with the General Division of the Tribunal.

[7] Paragraph 44(1)(b) of the CPP sets out the eligibility requirements for the CPP disability pension. To qualify for the disability pension, an applicant must:

(a) Be under 65 years of age;

(b) Not be in receipt of the CPP retirement pension;

(c) Be disabled; and

(d) Have made valid contributions to the CPP for not less than the Minimum Qualifying Period (MQP).

[8] The calculation of the MQP is important because a person must establish a severe and prolonged disability on or before the end of the MQP.

[9] Paragraph 42(2)(a) of the CPP defines disability as a physical or mental disability that is severe and prolonged. A person is considered to have a severe disability if he or she is incapable regularly of pursuing any substantially gainful occupation. A disability is prolonged if it is likely to be long continued and of indefinite duration or is likely to result in death.

ISSUE

[10] There was no issue regarding the MQP because the Tribunal found that the Appellant's updated earnings and contribution history (see Record of Earnings, p.GT7-5) established an MQP that would have ended on December 31, 2016, had the Appellant not began receiving early CPP retirement benefits in December 2011. Therefore, the last date the Appellant could qualify for a disability pension was November 30, 2011, and the Tribunal had to decide whether it was more likely than not that she had a severe and prolonged disability as of that date.

EVIDENCE

Documents

[11] In her Questionnaire for CPP Disability Benefits dated (p. 135), the Appellant disclosed that she suffers from a number of medical conditions, including a severe rotator cuff tear, myofascial strain in her lower back, arthritis in her right knee, severe headaches, sleep apnea and carpal tunnel syndrome. She claimed that these conditions disabled her from all forms of work. As a teacher, she was no longer able to write on a chalkboard because of pain and weakness in her right dominant upper extremity. She reported difficulty navigating stairs to classrooms because of pain and swelling in her knees. She was unable to fulfill outdoor duties, especially during the winter and in rainy conditions. Her short term memory was impaired and her sleeping patterns were irregular. She also suffered from chest pain and hearing loss, for which she wore two hearing aids.

[12] She was born in July 1950 and holds a Bachelor of Arts from York University and a teaching certificate from Toronto Teacher's College. She has been employed by the Toronto

District School Board (TDSB) since 1976. She listed among her medications Diovan (used to treat high blood pressure), Cipralex and Amitriptyline (both antidepressants), Percodan and Tylenol #3 (both narcotic pain relievers) and a puffer for asthma. She had also received physiotherapy, massage therapy and psychological counselling. She sometimes used a cane for support in rain and snow.

[13] In the initial CPP Medical Questionnaire dated May 21, 2012 (p. 112), Abraham Friesner, family physician, reported that the Appellant had multiple diagnoses, including depression, motor vehicle and work-related injuries, gastritis, hearing loss, bladder disorder, arthritis, anemia, possible carpal tunnel syndrome, bronchitis, obesity, lumbar strain, personal family problems, sinusitis, menopause, gallstones, neurodermitis, Bell's palsy, chest pain and hypertension. She felt she was eligible for CPP disability but had no written documentary support from her hematologist, urologist, dermatologist, ENT specialist or orthopedic surgeon. She might require shoulder surgery. Dr. Friesner noted that she usually felt her medication ineffective. The prognosis was "good."

[14] In a letter dated July 13, 2009 (p. 6), Daniel M. Somogyi, a specialist in physical and rehabilitation medicine, wrote that the Appellant had experienced right-sided wrist and hand numbness for many years on an intermittent basis, worse over the last six months. It was Dr. Somogyi's impression that her symptoms were slightly atypical for carpal tunnel syndrome on the right side. The electrophysiologic studies demonstrated moderate median neuropathy of the right wrist. The left side symptoms represented thumb CMC joint pain.

[15] In an undated letter (p. 135 – some pages missing), Rick Zarnett, an orthopedic surgeon, wrote that the Appellant was seen for complaints of pain to her right shoulder, low back and right knee as a result of tripping over a cardboard box in X in January 2011. Records from Sunnybrook Health Science Centre documented dislocation of the right anterior subgelnoid, subsequently reduced under sedation. Clinical notes indicated previous right shoulder symptoms and soft tissue injuries to her low back and right knee. She was in an accident in 1996 and underwent surgery to repair the rotator cuff. She was involved in at least two other incidents, including a work-related injury in which she suffered injuries to her right shoulder and low back. She reported some intermittent symptoms in the shoulder and back prior to her slip and fall

accident, although she did not produce any significant limitations or restrictions. She was working and able to perform all her normal daily activities. The accident caused a substantial change in her functional status. The MRI indicated a large rotator cuff tear, likely pre-dating the slip and fall, and she suffered myofascial strain to her low back. The low back had some tenderness but no other significant abnormalities. She had arthritis in her knees that predated the accident but was aggravated by it. She continued to have serious and permanent impairment of her right shoulder. Her ability to use her arm was limited for any heaving lifting, overhead activity or for pushing, pulling and reaching behind her back. She was not a candidate for surgical repair or tendon transfer. She underwent physical therapy and received a Cortisone injection without any significant improvement. She would require symptomatic treatment for her low back. She needed a psychological assessment, as her recovery would not be dependent on physical rehabilitation alone. She continued to be substantially unable to resume all activities of daily living and her pain limited her ability to resume her job as a teacher. She would require ongoing occupational therapy, support and follow-up to assist her in resuming her pre-accident home maintenance tasks, and she required ongoing attendant care assistance. Dr. Zarnett concluded that she sustained a permanent and serious impairment of an important physical function.

[16] In a letter dated July 14, 2010 (p. GT3-30), John Stimac, a cardiologist, wrote that the Appellant's chronic chest pain was probably of non-cardiac origin and more likely to be musculoskeletal.

[17] In a letter dated November 29, 2011 (p. 54), R.M. Holtby, an orthopedic surgeon, wrote that the Appellant was seen for right shoulder pain and possible reconstruction. Ten years earlier, she had surgery to repair her rotator cuff. The results were reasonably good, but she then developed multiple musculoskeletal symptoms over the years as a result of MVA and workplace-related injuries. She said she was functionally well overall and for the most part was continuing to work as a supply teacher. She had a slip and fall accident in January 2011, and despite conservative treatment with physiotherapy and Cortisone injections, continued to have problems, particularly with her right knee. On examination, she showed weakness in her right shoulder with pain on forward flexion to 40 degrees actively, increasing to 95 passively. External rotation was 20 degrees, internal rotation to the sacroiliac joint. Weakness of her supraspinatus was at grade

3/5 with grade 4/5 strength for the infraspinatus. Her *teres minor* appeared to be functioning. She exhibited equivocal belly press and bear hugger signs, suggesting there was some subscapularis function remaining. X-rays showed some migration of the humeral head with some probable degenerative change. The subacromial space otherwise looked reasonable, as one would expect following a previous rotator cuff decompression procedure. X-rays from Sunnybrook confirmed dislocation of her shoulder and subsequent reduction. The MRI showed a large supraspinatus and infraspinatus rotator cuff tear with some degenerative change in glenohumeral joint. Looking at her shoulder, she appeared to be significantly disabled subsequent to the dislocation of her shoulder. Dr. Holtby decided to order a new MRI before deciding whether there was a role for surgical treatment.

[18] In a letter dated February 21, 2012 (p. 96), David Wasserstein, resident for Dr. Holtby, reiterated the diagnosis of a massive rotator cuff tear with superior migration of humeral head, noting that her reported function and pain levels had not changed much since her last visit. She was looking for certification of some CPP documentation, but Dr. Holtby only felt comfortable filling out forms in context of her shoulder problems. "Unfortunately her situation is quite complicated." She was very frustrated and upset. It seemed that her mood was low, and she openly stated that she was depressed. She denied any intention to do harm to herself.

[19] In a letter dated February 27, 2012 (p. 83), Brian Kimball, a cardiologist, wrote that the Appellant continued to have very atypical chest pains with superficial tenderness. A cardiolite scan failed to demonstrate coronary occlusions. Dr. Kimball concluded that she was in the presence of a multitude of risk factors and likely had underlying but relatively minor-modest coronary arthrosclerosis. Testing suggested no immediate dangers, but she needed aggressive lifestyle changes and medical prophylaxis. Citing a syncopal episode in December 2011, Dr. Kimball reduced her Diovan and advised continuing with Aspirin and Omega 3 fatty acid supplementation. He also encouraged her to reintroduce CPAP use. She needed dietary changes, weight loss, smoking cessation and regular aerobic exercise.

[20] In a letter dated February 23, 2012 (p. 129), Carol Boychuk, an audiologist, wrote that the Appellant was seen for longstanding permanent moderate to severe sensorineural hearing loss in both ears. With hearing aids, she was fully functional and able to demonstrate 100 percent on

a word recognition test in a quiet environment. The noise test revealed a mild disability in competing messages in background noise. Her level of hearing would present a mild disability, even with hearing aids, in most communication situations.

[21] In a handwritten letter dated April 24, 2012 (p. 88), Aaron Malkin, a psychotherapist, described his assessment of the Appellant's mental condition, diagnosing her with major depressive disorder, anxiety disorder, not otherwise specified, and pain disorder. Dr. Malkin also found that she had a mixed personality disorder and was coping with numerous stressors, including an adverse reaction to medication and injuries resulting from a slip and fall accident and other injuries from a student assault. Dr. Malkin assigned her a Global Assessment of Functioning (GAF) score 45 to 50. As result, she was unfocused, depressed, sleep-deprived, memory-impaired and in constant pain. It was unclear when or if her physical problems would ever be resolved, but her psychological disorder was longstanding and severe. She had tried a number of medications without success over the prior five years. The bio-psychostressors continued unabated in varying forms and could take on catastrophic proportions. The latest was an outbreak of a generalized rash, presumably resulting from the simultaneous prescription of CymbaIta and an antibiotic for a urinary tract infection. In Dr. Malkin's opinion, the prognosis for her recovery from her mental disorders was quite poor, given the unrelenting psychotraumatic state in which she lived.

[22] In an Operative Report dated March 27, 2012 (p. 91), Richard Comisarow, a urologist, documented the Appellant's cystoscopy following complaints of stress and urge incontinence. No urethral stricture was observed, and the bladder interior was entirely unremarkable. She held a large amount of urine without discomfort.

[23] In a letter dated May 22, 2012 (p. 78), Dr. Friesner wrote that the Appellant's medical history was "quite complex," with prior diagnoses of depression, MVA injuries, gastritis, hearing loss, bladder incontinence, arthritis, carpal tunnel syndrome, obesity, lumbar spasm, menopause, maxillary sinusitis, gallstones, Bell's Palsy, anemia, among others. He treated her for nearly 20 years until 2004, when they parted ways following multiple disagreements about her tendency to self-medicate against his advice. He resumed seeing her in early 2011 and provided a detailed history of her injuries, symptoms, treatments, referrals and medications during the previous year.

She told him that her medications were making her fall asleep in the classroom. Dr. Friesner suggested that she was pressing him to sign disability forms before he had received relevant reports from specialists.

[24] In a letter dated June 13, 2012 (p. 51), Dr. Holtby wrote that he had seen the Appellant for follow up of her right shoulder pain. He considered rotator cuff repair but decided against it because she had multiple comorbidities. Even with a more functional shoulder, she would be quite disabled with her other problems and they would also affect the risk of complications in any surgical procedure. The likelihood of a good result would be small, and therefore the risk of surgery would probably not be worth taking. She still had some significant pain concerns, which would be best addressed by her family doctor. She would also benefit from pain management with the assistance of a psychologist.

[25] In a 24-Hour Ambulatory Blood Pressure Monitor Report dated June 26, 2012 (p. 58), Yeung Choi, a cardiologist, wrote that the Appellant's overall blood pressure load was 80 percent of all systolic blood pressures and 44 percent of all diastolic blood pressures. She exceeded the threshold of 140/90 while awake and 120/80 while asleep. Dr. Choi concluded that the Appellant had inadequate blood pressure control.

[26] In a letter dated June 28, 2012 (p. 52), Tommy Chan, an orthopedic surgeon, wrote that the Appellant had been having a problem with her right shoulder for a long time. She had a massive rotator cuff tear and was sent to Dr. Holtby, who did not feel there were any grounds for surgery. She was also complaining of pain in the right knee, and x-rays showed a moderate degree of degenerative arthritis. Dr. Chan gave her a Cortisone injection.

[27] Dr. Malkin completed the Disability Tax Credit Certificate for the Appellant on July 12, 2012 (p. 59), noting a marked restriction in hearing (began 1985), walking (1996), elimination (2010), feeding (2010), dressing (2010) and mental functions necessary for everyday life (2005). She had been diagnosed with major depression, generalized anxiety and a pain disorder. As a result of her impairments, she had a painful left shoulder and low back with radiculopathy affecting her ability to walk. She was unable to concentrate and her sleep was non-restorative. She had received Cortisone injections to her right knee and right shoulder. Her teaching time was markedly reduced because of pathology and cognitive impairment. Her impairment had lasted, or

was expected to last, for a continuous period of at least 12 months. Dr. Malkin was unsure whether the impairment had improved or was likely to improve.

[28] In a CPP Employer Questionnaire dated May 25, 2012 (p. 116), C. M., Occasional Teaching Officer with the TDSB, wrote that the Appellant was still working as supply teacher and on long-term contract five days per week. She had received regular assignments up to June 2012. Attached schedules indicated multiple days worked in 2011-12. Handwritten annotations (possibly by the Appellant) noted 132 days worked for the year ending in June 2010, 91 days in 2011 and 34 days in 2012—a "constant decline in work."

[29] In an undated letter (p. GT3-10), the Appellant wrote that the only reason she had pushed herself to continue teaching was because she lost her TDSB benefits for the 2012-13 school year, as she did not have the required number of days needed to qualify. A school year has 194 teaching days, and she had only been able to teach 53 to 93.5 days per year.

[30] In a letter dated February 12, 2014 (p. GT3-12), Ms. M. advised the Appellant that her name had been removed from the TDSB's Secondary Occasional Teaching roster for failure to complete the minimum number of days.

[31] In a letter dated November 19, 2013 (p. GT3-13), Dr. McGahey wrote that the Appellant retired effective January 31, 2008. From January 31, 2008 to June 30, 2008, she worked 73 days. In 2008-09, she worked 87.5 days. In 2009-10, she worked 100 days. In 2010-11, she worked 90.5 days. In 2011-12, she worked 54 days. In 2012-13, she worked 96 days.

[32] In a letter dated September 19, 2012 (p. GT3-18), Henry Lai, a specialist in pain management, set out a multidisciplinary plan of treatment for the Appellant, including use of mild opioids and nerve block injections.

[33] In a letter dated August 23, 2013 (p. GT3-28), Peter J. Weiler, an orthopedic surgeon, wrote that the Appellant had been diagnosed with bilateral arthritic knees and was interested in knee replacement.

[34] On September 16, 2013 (p. GT3-71 – partial pages only), Barbara Nagy, a physiotherapist, prepared a Preliminary Future Care Needs and Costs Analysis for the Appellant.

[35] In a letter dated September 27, 2013 (p. GT3-81), Dr. Kimball wrote that the Appellant continued to work as a supply teacher, but was having marked difficulty with ambulation, given her bilateral severe osteoarthritis. Dr. Kimball expressed disappointment that she had not kept up with their prior arrangement, having reduced her antihypertensives (Diovan) and fully eliminated anti-inflammatory medicines.

[36] In a letter dated March 13, 2013 (p. GT3 - 82), Ramin Safakish, a specialist in pain management, wrote that the Appellant was seen for medically-resistant neuropathic pain. He recommended intravenous Lidocaine and/or Ketamine infusions.

[37] In a letter dated January 27, 2014 (p. GT3-107), J. Schatzker, an orthopedic surgeon, wrote that the Appellant's spine was stable and there were no signs of neurological lesions. She was not a surgical candidate. Dr. Schatzker's diagnoses were chronic lower back pain, fibromyalgia, degenerative disc disease and obesity.

Testimony

[38] As the Appellant did not appear, no oral evidence was given.

SUBMISSIONS

[39] The Appellant did not appear at the hearing but it previous correspondence, she argued that she qualifies for a disability pension because:

(a) She has been diagnosed with numerous medical conditions, including a severe rotator cuff tear, myofascial strain in her lower back, arthritis in her right knee, severe headaches, depression, sleep apnea and CTS;

(b) As a result of these medical conditions, she suffers from pain and swelling in her joints, restrictions in movement, weakness and generalized fatigue, all of which render her incapable of any form of substantially gainful work;

(c) Despite her disabilities, she has done her best to remain employed, working as a supply teacher for as long as she was physically capable;

(d) She has attempted numerous treatment options, including physiotherapy, massage therapy and use of prescription painkillers and antidepressants, but none has provided any significant or long-term relief.

[40] The Respondent did not appear at the hearing, but in written submissions dated April 17, 2013 (p. GT3-4) and January 23, 2015 (p. GT7-1), it argued that that the Appellant does not qualify for a disability pension because:

(a) While her medical conditions may limit her from doing some types of tasks, there is nothing in the evidence to indicate that she is prevented from performing all forms of work;

(b) Above all else, the evidence indicates that, despite her described limitations, she did in fact continue to work as teacher in 2011, 2012 and 2013—after she was last eligible for a CPP disability pension. Her earnings in those years qualified as "substantially gainful."

ANALYSIS

[41] The Appellant must prove on a balance of probabilities that she had a severe and prolonged disability on or before the end of the MQP.

Severe

[42] The severe criterion must be assessed in a real world context (*Villani* v. *Canada* (*A.G.*), 2001 FCA 248). This means that when assessing a person's ability to work, the Tribunal must keep in mind factors such as age, level of education, language proficiency, and past work and life experience.

[43] In this case, evidence of a severe medical disability as of the MQP date was unpersuasive. While the Tribunal does not doubt that the Appellant has limitations, she did not present compelling evidence that she was incapacitated from regularly pursuing substantially gainful employment as of November 30, 2011.

[44] As noted by her family doctor, her medical history is quite complex, with injuries incurred in a number of different settings, including her workplace, a motor vehicle and a retail store. She has wide variety of symptoms and has been diagnosed with rotator cuff tear, myofascial lumbar strain, arthritis of the knees, headaches, depression, hearing loss, sleep apnea and carpal tunnel syndrome, among others. She has been assessed and treated by numerous healthcare professionals over the years, and the Tribunal suspected that the hearing file contained only a portion of her medical history.

[45] Several of the Appellant's claimed conditions struck the Tribunal as less than serious, in that they either manifested themselves with relatively mild symptomatology or were manageable with appropriate treatment. As indicated by the cardiology reports, she does have high blood pressure, but she has also been less than diligent about taking antihypertensives. Dr. Stimac concluded that her chest pains were likely musculoskeletal in nature. Audiology testing indicated that, while she does suffer from hearing loss, hearing aids fully restore her word recognition in a quiet environment and leave her with at most a mild disability when there is background noise. The Appellant's complaints of incontinence were found to have no physiological basis following a urological cystoscopy. Sleep apnea can be addressed through regular use of a CPAP device (for which the Appellant has apparently already been fitted).

[46] That said, the Appellant does have some obviously significant ailments. She has a long history of shoulder pain and weakness and underwent surgical repair sometime in the early part of the last decade. Repeated examinations have revealed a "massive" tear of the right rotator cuff and dislocation of the shoulder. In November 2011 (before the end of her MQP), she consulted an orthopedic specialist, Dr. Holtby, who after some deliberation eventually ruled out further surgery and left her to conservative measures such as analgesics and Cortisone injections. Dr. Holtby observed that she seemed "significantly disabled."

[47] At the time, the Appellant was also complaining of low back and right knee pain, and in August 2013 she was diagnosed with arthritis by Dr. Weiler. He recommended knee replacement surgery and the Appellant indicated in her recent postponement request that this procedure was in fact performed in May 2014 on the right side, with the left scheduled for the near future.

However, it must be noted that the surgery came more than two years after the Appellant last qualified for the disability benefit. Moreover, knee replacement surgery in itself is not evidence of disability, and it has been known to produce dramatic reductions in pain and improvement in mobility.

[48] The Appellant's depression also struck the Tribunal as something that might be potentially disabling. It was unclear how much psychological counselling she had received, but the one psychiatric assessment on file—Dr. Malkin's April 2012 report—diagnosed her with major depression and assigned her a GAF score that suggested significant impairment of vocational and social functioning. Dr. Malkin felt that the prognosis for her recovery was quite poor, given her "unrelenting" psychotrauma.

[49] Despite these medical conditions, the Appellant carried on working—and this is the major factor behind the Tribunal's decision not to allow this appeal. In her application for disability benefits, the Appellant claimed that she became disabled as of January 2011, the date of her slip and fall, yet she worked as a school teacher in 2011, 2012, 2013 and, according to her last letter to the Tribunal, the last part of 2014. She worked for the same employer she had had since 1976, and her documented earnings since 2011 can be fairly described as "substantially gainful."

[50] The Appellant has been injured on several occasions, but injuries do not necessarily cause lasting impairment. She has been diagnosed with a multitude of medical conditions—some of them seemingly serious—but diagnoses do not equate with disability. Despite her many ailments and her protestations of disability, she has demonstrated continuing vocational capacity for the past four years by repeatedly returning to the classroom for remunerative pay.

[51] According to C. M.'s letters, the Appellant formally retired from the TDSB in January 2008, but she carried on working—sometimes as an on-call supply teacher, sometimes as a long-term contractor—between 54 and 96 days per year (with an average school year having approximately instructional 190 days in total). The Appellant herself disclosed that she managed to work 32 days in the latter part of 2014, despite having undergone total right knee replacement surgery. While the Appellant has undoubtedly had to work through some measure of pain and discomfort during the past four years, the fact remains that she *was* working, earning $17,423 in

2011, $14,862 in 2012 and $25,597 in 2013. These figures were not inconsistent with the amounts she was earning in the years prior to her claimed date of disability onset ($13,219 in 2009 and $26,185 in 2010) and, in the view of the Tribunal, they are "substantially gainful." It is not inconceivable that one would be able to support oneself on such amounts, even in the Greater Toronto Area, with its relatively high cost of living.

[52] The Appellant's failure to appear did not assist her case. She was not available to describe in depth how her medical conditions combined to produce a severe disability nor to explain how she was able to work for half of a school year and earn almost $26,000 yet still claim to be unemployable.

[53] The CPP demands that an applicant's disability preclude *any* kind of regular, gainful employment—commensurate with her background and training—a rather high standard to meet. In the end, the evidence did not support the Appellant's claim that she was disabled as of November 30, 2011.

Prolonged

[54] As discussed above, the Appellant's claimed disability fell short of the severity threshold, so there is no need to consider whether her disability could be termed "prolonged."

CONCLUSION

[55] The appeal is therefore dismissed.

Member, General Division