Citation: ***K. L. v. Minister of Employment and Social Development*, 2015 SSTGDIS 36**

Date: May 5, 2015

File number: GT-120716

GENERAL DIVISION- Income Security Section

Between:

K. L.

Appellant

and

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

Respondent

Decision by: Jeffrey Steinberg, Member, General Division - Income Security Section

Heard by Videoconference on May 4, 2015

REASONS AND DECISION

PERSONS IN ATTENDANCE

K. L., the Appellant

D. A., the Appellant's representative

INTRODUCTION

[1] The Appellant's application for a *Canada Pension Plan* (CPP) disability pension was date stamped by the Respondent on Mach 25, 2011. 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.

[2] The hearing of this appeal was by Video Conference for the following reasons: i) videoconferencing is available in the area where the Appellant lives; ii) the issues under appeal are not complex; and iii) the form of hearing respects the requirement under the Social Security Tribunal Regulations to proceed as informally and quickly as circumstances, fairness and natural justice permit.

THE LAW

[3] 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 Social Security Tribunal.

[4] 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).

[5] 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.

[6] 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

[7] There was no issue regarding the MQP because the parties agree and the Tribunal finds that the MQP date is December 31, 2009.

[8] In this case, the Tribunal must decide if it is more likely than not that the Appellant had a severe and prolonged disability on or before December 31, 2009.

EVIDENCE

Documentary Evidence

[9] In the CPP Questionnaire dated March 21, 2011 the Appellant indicated that she stopped working March 3, 2008 as a public health nurse due to medical illness. She described depression, chronic renal failure, anemia, chronic fatigue, nausea, pressure in the head and encephalitis (inflammation of brain). She further described, among other things, lack of energy, pain, weakness, poor concentration, poor memory, difficulty driving, limited physical activity and difficulty understanding. She further described difficulty swallowing, sleeping, lightheadedness, osteoporosis, chest pains and difficulty breathing. She indicated she can sit/stand for 1-2 hours, walk less than one hour, lift/carry 11-20 lbs. for a short distance and has limitations performing household maintenance activities due to fatigue and lack of energy. She is prescribed Imovane for sleep.

[10] The Appellant completed Grade 13 and a Bachelor's Degree in nursing.

[11] On April 22, 2011, Dr. Jones, family physician, completed the CPP Medical Report. She indicated she knew the Appellant for five and one-half months and diagnosed chronic renal insufficiency – stage III; Adjustment Disorder with depressed mood; panic disorder (possible); chronic fatigue/insomnia; asthma and septic meningitis (2011). She stated that during the past two years, the Appellant underwent a hysterectomy (March 2010); post-operative acute renal failure (April 2010) with uretic stents for bilateral hydronephrosis (water inside kidney) and stent removals in June and August 2010. She stated: "Current functional limitations are due to multiple and varied physical complaints including pain, headaches, fatigue, poor concentration". There are no diagnostic findings to date for the patient's main symptoms, however she is still under investigation. These symptoms may also be somatic manifestations of the patient's psychological diagnosis." Dr. Jones stated the Appellant had been referred to a psychiatrist for possible initiation of pharmacotherapy and psychotherapy and was consulting with a nephrologist (Dr. Lenga) and general internist (Dr. Marqus). Under Prognosis, Dr. Jones wrote: "Chronic renal failure – currently stable. Progression/deterioration is possible. Adjustment Disorder with depressed mood – improvement likely once appropriate treatment achieved and physical medical/issues resolved".

[12] On April 22, 2010, Dr. Lenga, nephrologist, assessed the Appellant for acute chronic renal insufficiency due to bilateral hydronephrosis. She reported that the Appellant's past medical history included Stage III chronic kidney disease secondary possibly to NSAID toxicity due to chronic usage for endometriosis pain; long-term endometriosis; depression, chronic fatigue and insomnia longstanding; childhood asthma longstanding, atypical chest pain with episodes of SVT since 1997; and chronic dysphagia secondary to increased lower esophageal sphincter. Dr. Lenga reported that the Appellant had a total abdominal hysterectomy and unilateral oophorectomy three weeks earlier. During the previous two weeks, she complained of general malaise, nausea, lethargy, poor oral intake and left quadrant pain. Blood work showed elevated creatinine. A CT scan revealed marked right and moderate left hydronephrosis. Her right ureter appeared to be "kinked" on ureteroscopy. Therefore, she had bilateral stents inserted and her creatinine decreased. According to Dr. Lenga, the

bilateral hydronephrosis likely developed postoperatively and explained the reduction in renal function. With her improved creatinine, he intended to discharge her home.

[13] On June 18, 2010, Dr. Lenga saw the Appellant in follow-up regarding her acute chronic renal insufficiency secondary to uretic obstruction post hysterectomy and unilateral oophorectomy. He stated her renal function had improved with decreased creatinine. On examination, she appeared well. According to Dr. Lenga, the Appellant's renal function had improved but was not yet back to her previous baseline. She still complained of fatigue, occasional flank pain and nausea. He stated: "At this point, I cannot imagine they are attributable to her renal dysfunction."

[14] On September 16, 2010, Dr. Lenga saw the Appellant in follow- up. He reported that a June 2010 cystoscopy and pyelogram showed some evidence of narrowing at the distal ureter. Therefore, her right stent was reinserted but ultimately removed in August 2010. He reported that her renal function had improved and that her creatinine was down to 130, which was "right down to her previous baseline of 120-140". He stated: "While she still has some occasional fatigue issues, this is not attributable to her renal dysfunction." He indicated that her symptoms had improved and hopefully would continue to do so.

[15] On October 5, 2010, Dr. Marqus, internal medicine, assessed the Appellant. He indicated a "problem list" consisting of i) investigation for hot flashes and vaginal dryness; ii) investigation for throat discomfort; iii) investigation for fatigability; iv) chronic renal failure; v) prior history of endometriosis with a hysterectomy; vi) spontaneous abortion in 2005 due to large uterine fibroid; vii) depression with insomnia; viii) childhood asthma; and ix) atypical chest pain with SVT. He described the Appellant's recent history of hysterectomy for endometriosis followed by renal failure which was improved after relief of her obstructive uropathy with stenting. He reported she was much improved and that her recent kidney function test showed her creatinine levels at130. He stated she had a significant issue with what looked like hot flashes, estrogen deficiency, feeling fatigued and not sleeping. He also noted throat discomfort and difficulty swallowing. He further noted she had past investigation for GI motility but had refused a calcium channel blocker which was recommended.
Dr. Marqus stated the Appellant needed to have a family doctor look after her active medical

problems. Regarding her swallowing problem, he wondered if there was a motility disorder due to scleroderma and sent her for blood work and booked an upper GI. He also booked an ultrasound of the thyroid to rule out a thyroid nodule and requested a blood work screen for fatigability.

[16] A November 5, 2010 Upper GI series and small bowel follow-through revealed appearance of esophagus reflecting considerable spasm and possible motility disorder. However, a significant motility disorder such as achalasia (disorder of esophagus) was not identified.

[17] On November 23, 2010, Dr. Marqus reported that the Upper GI was significant for considerable spasm and possible motility disorder. He stated the Appellant was previously diagnosed with hypertensive lower esophageal sphincter spasm and was advised to start Cardizem (for hypertension and chest pain) but was reluctant to do so given her other medical issues. He discussed her symptoms of nonspecific headache, some problems with the left eye involving dimmed vision and cloudiness, joint swelling at the proximal PIP and vaginal and mouth dryness. He considered the possibility of Sjorgren's syndrome, a parasitic infection of the esophagus called Chagas disease and esophageal motility disorder of the lower end of the esophagus. He indicated they had to find a cause for her fatigability and "fogginess" in her CNS function and stated he would send her for serology".

[18] On December 15, 2010, Angela Calvert, Certificate Kinesiologist and certified Work Capacity Evaluator candidate, reported on the Functional Abilities Evaluation (FAE) comprehensive assessment of the Appellant. The purpose was to objectively define her current safe functional ability. According to Ms. Calvert, the Appellant terminated the assessment prior to completion. Therefore, her safe work day tolerances could not be determined. However, Ms. Calvert did not note any functional deficits with attempted testing. According to Ms. Calvert, the Appellant demonstrated the ability to maintain positions of sitting and standing.

[19] On December 22, 2010, the Appellant underwent an Independent Psychiatric Medical Examination conducted by Dr. Jeffries, psychiatrist, who reported that the Appellant stopped working in 2007 because of depression. She complained of poor quality sleep and waking and

shortness of breath in relation to which she indicated she previously visited the emergency hospital room. Dr. Jeffries noted complaints of difficulty swallowing (a recent upper GI showing some spasm in the esophagus); some chest pain; irregular heart beat contributing to shortness of breath; feeling "something wrong inside"; asthma; acute renal failure followed by septicemia; fatigue; forgetfulness and lack of concentration; pressure in her head; feeling sad and frustrated; anemia; and chronic renal insufficiency, which she indicated was not bothering her much recently. Dr. Jeffries noted the Appellant prepared a 30 page summary of notes concerning her health in which she also complained about hot flashes, vaginal dryness, a lump in her throat, swollen glands and gallstone. He further noted she had a miscarriage in 2005 and saw a psychiatrist who prescribed Celexa. He stated she had a sleep study in 2009 at which time Dr. Buttoo diagnosed periodic limb movement disorder and that Dr. Hennes, the then family physician, wrote to Manulife, stating that the Appellant was clinically depressed and unfit for work. In March 2009, Dr. Butto wrote that "anxiety and depression are playing a significant role." He referred the Appellant to Dr. Schneider, who wrote in May 2009 that she was becoming increasingly depressed, was crying a lot, was unable to concentrate, and was fatigued and hopeless with poor memory, lack of energy and social withdrawal. Dr. Schneider stated she had difficulty getting things done, had suicidal feelings and on one occasion tried to jump out of her husband's moving car. On a few occasions, she was admitted to hospital for suicidal thoughts.

[20] According to Dr. Jeffries, the Appellant had an Adjustment Disorder with depressed mood of severe degree. He was also suspicious she had panic disorder without agoraphobia. He stated it might be an overstatement to describe her as having a somatization disorder as "she clearly has serious physical problems and she does appear to have become very fixated on her physical state". He stated the significant features of her current symptoms were feelings of sadness and frustration with occasional suicidal ideation and more persistent wishes for death; and shortness of breath which he suspected may represent panic -although it may also have physical origin. He stated her cognitive abilities were somewhat impaired. Although her memory did not appear as poor as she described it, nevertheless, it was clearly impaired. Dr. Jeffries recommended an antidepressant and treatment by a psychiatrist. He noted she was somewhat resistant to psychiatric intervention because she was "eager to get a

physical diagnosis". He stated that she was "so somatically fixated at this time that she cannot focus on work".

[21] A March 1, 2011 CT of the abdomen revealed cholelithiasis.

[22] On March 2, 2011, Dr. Crisp, internal medicine, reported that the Appellant complained of intermittent headache for the past 3 years, which she described as tight pressure in her head, a feeling of blockage in her ears and some nausea. Episodes would last for about a week and occur roughly once or twice a month. Dr. Crisp reported that the Appellant initially attended the hospital, was assessed and then released thinking her headaches were benign. She was subsequently found unconscious at home and brought back to the hospital. According to Dr. Crisp, the Appellant presented by history with a non-specific viral type illness with confirmed evidence of a superimposed aseptic meningitis. He stated that the headaches leading up to her headache were some sort of migraine type headaches. The same day, Dr. Silverman assessed the Appellant for aseptic meningitis. He agreed she presented with aseptic meningitis but felt an MRI was required to rule out encephalitis. On or around March 21, 2011, Dr. Silverman reported the Appellant's brain MRI was normal as were repeat chest x-rays. She was back to her baseline symptoms. He noted she had chronic problem with depression and chronic mild renal insufficiency. She indicated she had swallowing issues, chronic nausea and occasional headaches. She referred to her headaches as both mild and "a real problem". Dr. Silverman suggested if they were an ongoing problem, she could be referred to a neurologist.

[23] In her Notice of Readiness dated March 28, 2014, the Appellant reported the following additional appointments and/or seeing the following physicians:

- March 4, 2012 Emergency admission by ambulance to Toronto Western Hospital.

- January 27, 2013 Emergency visit to Sunnybrook Hospital due to breathing problems, uncontrolled asthma, chest pains, pain in joints, light-headedness and poor concentration.

- February 27, 2014 Emergency visit to Lake Ridge Health due to difficulty breathing, head pressure and neck stiffness.

- Dr. Christine Lay, neurologist, in October 2012, January 2013 and April 2014.
- Dr. Gawel, neurologist, in November 2011, November 22, 2011, November 29, 2011, January 4, 2012 and January 2012.
- Dr. Lenga, nephrologist, in November 2011 and December 2013.
- Dr. Philteos, respirologist, regarding difficulty breathing on March 4, 2014 with a follow up appointment on May 29, 2014.
- Dr. Jones, physician, with chief complaints of severe head pressure, difficulty breathing, flank pain, ongoing investigation of kidney infection/obstruction and sickle cell screening: in May 2013, December 3013 and February 2014.
- Dr. Thagaroopan, psychiatrist, in September 2011.
- Dr. Yatfynovich, psychiatrist, in October 26, 2012 and January 24, 2013.
- Dr. Hank Frazer and consultants, psychologist, in November 2013, January 2014 and February 2014: diagnosis of Major Depressive Disorder and mixed anxiety due to chronic medical conditions. Referral to Dr. Gary Challis, with expertise in managing medical issues associated with depression.

[24] On August 18, 2014, the Appellant reported she saw the following specialists:

- Dr. Tremblay, gynecologist, who prescribed a treatment plan and medication for insomnia and hormonal change. She was seen on March 3, 2014 and May 13, 2014.
- Dr. Goussev, General Surgeon on April 1, 2014 about gallbladder surgery.
- Dr. Lay, neurologist, on April 7, 2014 for new medication.
- Dr. Philteos, respirology, on May 29, 2014. He assessed her asthma and reviewed her deteriorating condition.

- Dr. Fraser and Consultants, psychologist, on June 5, 2014. She had a psychological assessment and follow up.

[25] On March 1, 2015, the Appellant reported she saw the following specialists:

- Dr. Christine Lay, neurologist, on September 10, 2014 and March 4, 2015. She was seen for ongoing neurological assessment and treatment of chronic head pressure.

- Dr. Gevorgyan, otolaryngologist, for the possibility of a small pulsion diverticulum in the distal esophagus. She was referred to GI specialist, Dr. Green, for further investigation in September and December 2014 and February 2015.

- Ambulatory Emergency Admission, Ajax Pickering Hospital, for severe chest pain and difficulty breathing. She was referred to cardiologist, Dr. Burstein on October 19, 2014.

- Dr. Ilana Lenga, on November 11, 2014 for management of chronic kidney failure.

- Dr. Challis psychologist, on December 15, 2014 for management of medical issues associated with depression.

Oral Testimony

[26] In response to questions from the Tribunal, the Appellant clarified she did not follow up with Dr. Marqus. Given her multiplicity of conditions, he referred her to Dr. Jones, family physician, who referred her to other specialists.

[27] She did not see Dr. Jeffries in follow-up. He recommended she see a treating psychiatrist. With assistance from her legal representative, the Appellant clarified she has seen a number of psychiatrists and therapists in follow up. She saw Dr. Thagaroopan, psychiatrist, in September 2011. He was not the right doctor for her. He only wanted to treat her with medication. However, she felt her body was not metabolizing medication well given her

kidney function. She stated that taking such medication would make her feel worse. She also saw Dr. Yatfynovich, psychiatrist. He wanted to perform shock therapy on her. She disagreed with this course of treatment. She previously saw Dr. Schneider. She also saw Dr. Fraser, psychologist and consultants, for psychotherapy. Specifically, she saw Marlene, a psychotherapist associated with Dr. Fraser. They would discuss how to cope with her negative feelings and frustration about feeling sick for so long. Dr. Fraser eventually referred her to see a psychologist who treats depressive mood disorder associated with chronic medical issues. She sees Dr. Challis, psychotherapist, about once every three months. She believes she started to see him sometime after June 2014. She does not know how the therapy will turn out. However, it is not enough. Insurance only pays so much. Also, Dr. Challis is not always available when she needs to talk to someone. When she feels unwell, emotionally, it takes a toll. She continues to struggle with this. She also calls the Suicide Hotline frequently as she needs encouragement. She is frustrated feeling ill all the time and not having answers. She typically will call at night about once a week. She intermittently calls the Suicide Hotline due to its accessibility. She cannot recall if she called the Suicide Hotline in 2009. She cannot "get around" the fact of her hysterectomy, inability to have children, miscarriage and lack of energy. This is not the life she chooses to live. She also saw Dr. Jeffries in 2010 who performed an Independent Medical Examination.

[28] On March 4, 2014, she was taken by ambulance to the hospital as she was non-responsive. The Appellant's representative (her spouse) explained the Appellant fainted when she had her cat put down at the Veterinary Hospital. She was taken to the hospital and kept overnight for observation.

[29] On January 27, 2013, she had an emergency visit to Sunnybrook Hospital due to breathing problems, asthma, chest pains, joint pains, light headedness and poor concentration. She thinks they performed a brain scan but is uncertain.

[30] On February 27, 2014, she had an emergency visit to Lakeridge Health due to difficulty breathing, head pressure and neck stiffness. She does not know if they found anything and stated they "rarely do." She explained her body does not present "the average

way" when the doctors assess her, which leaves them with a false impression she is okay when she is not okay and is not feeling well.

[31] She initially saw Dr. Gawal, neurologist in 2011. He referred her to Dr. Lay, neurologist, Women's College Hospital. Dr. Lay is trying to help her with the pressure in her head, which is debilitating. They use vitamins, are trying to change her blood chemistry and employ mindfulness and medication. The medication is sometimes effective and other times not. She also has sensitivity to light. She felt pressure in her head even before she had meningitis. Dr. Silverman stated they may have removed too much fluid from her spinal cord when she underwent two lumbar punctures, which may be causing the sensation of pressure in her head. The pressure feels as though her head is too small for her skull. She experiences the sensation frequently and unpredictably. When it happens, she does not get much done. It is very painful and she gets nauseated and even more sensitive to light. She feels tired afterward as her body recovers. She will see Dr. Lay for follow up in September 2015.

[32] She regularly sees Dr. Lenga, nephrologist, for monitoring. Although her kidneys are stable, they are not "great". If she gets too dehydrated or takes medication to treat other conditions, this affects her kidneys.

[33] She saw Dr. Philteos, respirology, in 2014 for her asthma. Her father died from asthma at age 44. She is surprised she is still here. Her condition has worsened since 2010. Dr. Philteos "aggressively" placed her on medication for COPD. Her pharmacist and allergist said it was causing harm. She is trying another approach by trying to better control her allergies which may decrease her asthma attacks. She always feels as though she is short of breath. She is also allergic to a lot of things. She is anaphylactic to sesame seed and sesame seed products. The product is everywhere.

[34] She did not want to continue seeing Dr. Schneider, psychiatrist, who works out of a hospital. She knows other nurses who work at the same hospital. She did not like the stigma and invasion of privacy of the other nurses seeing her attend treatment.

[35] She saw Dr. Tremblay, gynecologist, in 2014 for insomnia and hormonal changes. Despite some improvement, she still has insomnia. Dr. Tremblay has since retired and Dr. Jones has referred her to a menopause clinic for July 2015.

[36] She saw Dr. Goussev, general surgeon, in 2014 for gallstones. He stated the gallstones were probably responsible for a lot of her previous infections. He stated she was too sick for him to operate on but not old enough to consider a medical treatment, which he stated would destroy her liver. He did not give her a lot of hope. She will see another doctor for a second opinion.

[37] In 2014 and 2015, she saw Dr. Lay, who prescribed medication for her head pressure. Sometimes it works and sometimes it doesn't. If her kidneys act up, she does not take the medication. She uses it sparingly.

[38] In 2014 and 2015, she saw Dr. Gevorgyan, otolaryngologist, for her swallowing problems. They found something suspicious that they need to investigate. She will undergo gastroscopy in June 2015 and see Dr. Green, another specialist. The swallowing also affects her sleep due to constant pressure in her throat.

[39] In October 2014, she had an emergency admission to Ajax Hospital with chest pain and difficulty breathing. She followed up with Dr. Bernstein who did a stress test. He will keep her "under his wing" for a year.

[40] The Appellant's representative clarified the Appellant did not have current employment income in 2013 and 2014. The income on her Record of Earnings is on account of her group disability benefits, not current employment earnings. She initially qualified for short-term disability benefits and then went on long-term disability benefits. She has not worked since December 2008

[41] As of December 2009, she and her spouse lived together in a house. She could not say which of her conditions was the worst at the time since different conditions appear at different times. Between then and now, her depression has been the most problematic relating to all her other conditions. It is a "never-ending cycle". When she thinks she is "out of the woods", something else in her body breaks down.

[42] She has required her spouse's assistance to help with day-to-day tasks. Depending on "where and when", she requires help. CCAC came to the house to change her IVs. Her spouse would keep her "afloat". Her mother and family members would help out. Throughout the years, family help with daily things. Her spouse does the grocery shopping as she does not have the energy to do so. Her mother calls to remind her to eat when she is too depressed to do so.

[43] In 2009, she could shower, bathe and dress herself independently. She would do some house work but would generally feel tired and unwell. Her spouse did most of the housework.

[44] She has a driver's license but stays close to home and does not often leave the house. However, about one week ago, she drove to a local grocery store to pick up a few items. If she has the necessary energy, she may do this between 0-4 times a month. Sometimes she does not leave the house at all; other times she has a spurt of energy.

[45] The Appellant testified she has not travelled. Her spouse clarified that in 2014, they travelled to his daughter's (the Appellant's step-daughter's) graduation ceremony in X for a few days. In 2013, they travelled to X for a 10 day family trip. In 2011, they went to a funeral in X. The graduation and funeral were paramount and she felt well enough to travel in 2011.

[46] Her sleep was poor in 2009 and remains poor today. She also has restless leg syndrome which keeps her awake. She finds it hard to fall and stay asleep. She averages about 4 hours sleep a night. She is tired during the day.

[47] She currently takes medication for her head pressure; Rhinocort twice daily; Symbocort (higher dosage than typical – up to 8x daily); Ventolin; (she previously took Nexium for her throat but is awaiting further investigations); and Imovane for sleep. She does not take anything for depression or anxiety as such medications make her feel more suicidal.

[48] She does not have the energy required to socialize.

[49] She has not sought retraining, looked for other work or pursued volunteer work since she last worked. She has not felt well enough to do so. She deals with her frequent and unpredictable conditions. No employer would hire her given the unpredictable nature of her conditions. There is no job she could see herself doing.

[50] She feels she has fallen "into a crack" in the system as she tries to understand what is happening to her and why. Much has not yet been discovered. She feels frustrated. She is "stuck" feeling unwell, unable to work and unable to have the life she used to have. She has no energy. She could not even perform part-time work. She cannot guarantee she would be well that day. Her husband "keeps me here". She used to have a much better memory. With lack of rest, her memory has changed considerably.

SUBMISSIONS

[51] The Appellant submitted that she qualifies for a disability pension because:

a) The medical record supports the existence of chronic kidney failure (2005 to present); asthma (childhood to present); anemia (2005 to present); insomnia (2005 to present); depression (2005 to present); shortness of breath 2005 to present); heart problems 1997 to 2000; neurological head pressure (2005 to present). She had surgery/hospitalization as follows: chronic kidney failure (April 23, June 23, July 13, August 24, September 16, 2010); hysterectomy (March 26, 2010); chest pain/shortness of breath (August 21, 2007); severe back pain/ovaries (June 23, 24, 2006); kidney disease (March 4, 2010); kidney ultrasound (2011 and follow up with Dr. Lenga in November 2011); shortness of breath (August 2008) and neurological head pressure (March 2011) and ongoing assessment.

b) Between 2001 and 2008, she worked full-time as a nurse. She has been unable to work at any job since 2008.

c) She has been diagnosed with Adjustment Disorder with depressed mood, chronic fatigue, insomnia, chronic asthma and aseptic meningitis. The physical findings are "current functional limitations due to multiple varied physical

complaints”. She is still under investigation. She has been referred to a psychiatrist for psychotherapy and has ongoing consultation with a nephrologist and internist. She has multiple physical limitations. The psychologist says she is unable to work at any job.

d) Between December 2007 and November 2010, Dr. Hennes consistently requested she be placed on disability benefits. According to Dr. Hennes, she was unable to perform her regular job duties due to health reasons.

e) On April 15, 2009, Dr. Odueke reported she “presented with a history of heavy and prolonged periods over 3 years” and other conditions including kidney failure, sleep disorder, asthma, endometriosis and depression.

f) On May 27, 2009, Dr. Buttoo stated her chief complaint was unrefreshing sleep and insomnia since 2005. It has not improved and she requires medication to fall asleep. According to Dr. Buttoo, psychiatric factors of “anxiety and depression are playing a significant role.”

g) On July 19, 2010, Dr. Morton reported she “presents with a well-documented history of increasing renal dysfunction with signs of significant right hydronephrosis, perhaps mild left hydronephrosis with poorly functioning left kidney post hysterectomy.”

h) On December 22, 2010, Dr. Jeffries stated she has “an adjustment disorder with depressed mood. It is of severe degree”. He stated he did not think she was against working. However, she was “so somatically fixated at this time that she cannot focus on work”.

i) She has been incapable of pursuing any gainful occupation as of December 2009 due to a severe and prolonged disability.

j) She has an extensive list of medications. She has tried whatever her doctors have recommended. However, she discontinues medication if it makes her feel

worse. She had made her best effort to feel better as she wants to return to work.

k) She attempted some on line tutorials last year to see if she could pursue online retraining. Due to problems involving memory and concentration, she was unable to continue[1].

l) She cannot cope with a job. She has no predictability in terms of getting ready in the morning, getting to a job and committing to it.

m) She received a letter from the Director, Pension, Payroll and Employee Benefit Division on March 15, 2012 stating that effective April 2012: "Employee will receive a T4 from the City of X showing contribution to CPP and EI for personal Income Tax remittance." The City of X remains her current employer and earnings from 2012 and 2013 are Basic Long Term Disability benefit earnings.

[52] The Respondent submitted that the Appellant does not qualify for a disability pension because:

a) According to the information she provided in her August 2011 reconsideration request, she was seen in 2009 for gynecological symptoms, kidney failure, sleep disorder, asthma and depression. Options for managing her symptoms were discussed.

b) According to her internal specialist's 2010 report, she underwent a hysterectomy and went into renal failure which improved following surgical intervention. This was complicated by infection that was successfully treated; she continued with some health issues including throat discomfort for which a calcium channel blocker was suggested, which she refused;

c) According to her infection specialist's March 2012 report, she was treated successfully for aseptic meningitis;

[1] the Appellant did not testify to this during her oral testimony.

d) According to the December 2010 FAE, her overall strength category could not be determined as she ended testing prematurely. However, no difficulty or functional deficits were noted in testing prior to termination. She demonstrated ability to maintain sitting and standing.

e) According to the December 2010 psychiatry report, she could not work at that time due to a number of medical conditions – but none were severe. She was fixated on physical issues and diagnosed with adjustment disorder with depressed mood.

f) According to the neurologist's March 2011 report, her neurology exam was normal.

g) According to the internal medicine/infection disease specialist's March 2011 report, she was reassessed regarding aseptic meningitis. She was back to baseline symptoms.

h) According to the April 2011 family physician report, she has chronic renal insufficiency stage III, adjustment disorder with depressed mood, possible panic disorder, chronic fatigue, insomnia, asthma and aseptic meningitis. Her chronic renal failure is stable and it can be anticipated that with appropriate psychiatric treatment and physical/medical issues resolved, her adjustment disorder with depressed mood will improve.

i) According to the information provided in her Questionnaire, she reported difficulties with fatigue and cognition. Mild physical limitations were noted. She was prescribed sleep medication.

j) According to the April 2011 Medical Report, there are no diagnostic physical findings to date for her main symptoms. She has been referred for possible initiation of psychotherapy and pharmacotherapy. Her renal function is stable and her mental health issues are likely to improve. The information does not support a severe medical condition preventing all types of work in the foreseeable future.

k) Her symptoms may be somatic manifestations of her psychological diagnosis. It could be anticipated that with specialized psychiatric treatment and compliance with medication she would improve.

l) Although she claims to have stopped working in March 2008, a review of her earnings and contributions reveal that she made further contributions in the 2012 and 2013 tax years in the amounts of $38,901.00 in 2012 and $50,363.00 in 2013. The Record of Earnings reveals the earnings were received from her previous employer, the City of X.

ANALYSIS

[53] The Appellant must prove on a balance of probabilities that she had a severe and prolonged disability on or before December 31, 2009.

Severe

[54] The Tribunal is satisfied that the Appellant's disability was severe on or before the MQP.

[55] The Tribunal accepts the Appellant's explanation that the earnings attributable to her in 2012 and 2013 were on account of Basic Long Term Disability Benefits and not current employment earnings.

[56] Although the Appellant has been able to travel on three occasions outside of Canada between 2011 and 2014, the Tribunal does not find that her ability to do so translates into a capacity regularly to pursue a substantially gainful occupation. Neither does her ability to drive a short distance up to 4 times a month (sometimes less) to pick up a few items at a local grocery store.

[57] The Tribunal finds that the main condition contributing to the severity of the Appellant's disability is her psychological condition whether labelled as Adjustment Disorder with Depressed Mood (see April 22, 2011 report of Dr. Jones at GT1-47) or Adjustment Disorder with Depressed mood of severe degree and suspicion of panic disorder without

agoraphobia (see December 22, 2010 Independent Psychiatric Medical Examination of Dr. Jeffries at GT1-64).

[58] Dr. Jeffries set out the Appellant's history. He stated she indicated she stopped working due to depression and complained of poor quality sleep, waking and shortness of breath. He noted that in 2009 (prior to the MQP), Dr. Hennes, family physician at the time, wrote to the Appellant's disability insurer, stating that the Appellant was clinically depressed and unfit for work and that Dr. Buttoo wrote that "anxiety and depression are playing a significant role". Dr. Jeffries further reported that the Appellant saw Dr. Schneider, who wrote in May 2009 (again prior to the MQP) that the Appellant was becoming increasingly depressed, was crying a lot, was unable to concentrate, was fatigued and hopeless with poor memory, lack of energy and social withdrawal. According to Dr. Jeffries, Dr. Schneider reported that the Appellant had "difficulty getting things done," had suicidal feelings, on one occasion tried to jump out of her husband's moving car and had been admitted to the hospital on a few occasions for suicidal thoughts. Dr. Jeffries stated the significant features of the Appellant's current symptoms were feelings of sadness and frustration with occasional suicidal ideation and more persistent wishes for death, shortness of breath (which he suspected may have represented panic) and somewhat impaired cognitive abilities. Dr. Jeffries recommended an antidepressant and treatment by a psychiatrist, although he noted the Appellant was somewhat resistant to psychiatric intervention because she was "eager to get a physical diagnosis". He further noted she was "so somatically fixated at this time that she cannot focus on work".

[59] The Tribunal is satisfied the Appellant suffered the onset of a severely disabling mental impairment in May 2009 at which time Dr. Schneider reported, as recounted by Dr. Jeffries, significant functional impairment, including the fact she was having "difficulty getting things done." By the time the Appellant saw Dr. Jeffries in December 2010, he reported she was so "somatically fixated" she could not focus on work. He further described impaired cognitive abilities and feeling of sadness, frustration and some suicidal ideation of more persistent wishes for death.

[60] The Appellant also suffers from a myriad of other physical conditions, none of which the Tribunal finds render her severely disabled when considered in isolation. However, when

considered in relation to her mental impairment which causes her to "fixate somatically" on her undiagnosed/unresolved conditions, the Tribunal finds that these other conditions take on added significance and contribute to her overall disability. These other conditions include, among others, throat discomfort, fatigability, poor sleep, GI motility problems including spasm, and non-specific headache. Significantly, Dr. Marqus indicated they had to find a cause for her fatigability and "fogginess" in her CNS function. In terms of headaches, Dr. Crisp, internal medicine, noted in his March 2011 report that the Appellant had complained of intermittent headache for the past 3 years (which time frame pre-dates the MQP) consisting of tight pressure in the head, a feeling of blockage in the ears and some nausea. The Appellant described episodes as lasting for about a week and occurring roughly once or twice a month. Dr. Crisps characterized them as some sort of migraine type headaches.

[61] The Tribunal is satisfied, given the Appellant's Adjustment Disorder with depressed mood and accompanying symptoms of chronic fatigue/insomnia, intermittent headaches, sensation of pressure in her head, which she describes as debilitating, stomach problems and throat discomfort, she was incapable regularly of pursuing any substantially gainful occupation on or before the MQP. Given her "somatic fixation" with her myriad of problems, the Tribunal is satisfied she would not be able, as reported by Dr. Jeffries, to focus on work.

[62] In conclusion on this point, the Tribunal is satisfied that the Appellant suffered the onset of a severe disability as of May 2009 at which time Dr. Schneider reported significant functional impairment. This included the fact she was become increasingly depressed, was crying a lot, was unable to concentrate, was fatigued and hopeless with poor memory, had lack of energy and was socially withdrawn. Dr. Schneider also reported the Appellant had difficulty getting things done, had suicidal feelings and on one occasion, tried jumping out of her husband's moving car.

Prolonged

[63] The Tribunal is satisfied the Appellant's disability is prolonged. Although she was diagnosed with depressive symptomatology in May 2009 and was described as having "difficulty getting things done", almost one year after the MQP in December 2010, Dr. Jeffries diagnosed Adjustment Disorder with depressed mood of severe degree. As previously noted,

he stated she was “so somatically fixated at this time that she cannot focus on work”. At the time of hearing many years after the MQP, the Appellant painted a similar picture through her oral testimony.

[64] Although Dr. Jones stated in the April 2011 CPP Medical Report that improvement of the Appellant’s Adjustment Disorder would be likely once appropriate treatment was achieved and physical medical/issues resolved, she indicated that the Appellant had been referred to a psychiatrist for possible initiation of pharmacotherapy and psychotherapy. She was also consulting with a nephrologist and general internist.

[65] At this time, the Tribunal finds it remains entirely speculative whether the Appellant’s disability will abate or resolve with pharmacotherapy, psychotherapy and ongoing consultation for her other medical problems. However, given the Appellant’s evidence that she receives ongoing treatment from Dr. Challis for her psychological condition and currently contacts the Suicide Hotline on a regular basis to help her cope, combined with the fact her myriad of physical conditions continue to be investigated, the Tribunal concludes the Appellant’s disability remains severe.

CONCLUSION

[66] The Tribunal finds that the Appellant had a severe and prolonged disability as of May 2009 when Dr. Schneider reported significant functional impairment of psychological origin. For payment purposes, a person cannot be deemed disabled more than fifteen months before the Respondent received the application for a disability pension (paragraph 42(2)(b) CPP). The application was received in March 2011; therefore the Appellant is deemed disabled in December 2009. According to section 69 of the CPP, payments start four months after the deemed date of disability. Payments will start as of April 2010.

[67] The appeal is allowed.

Jeffrey Steinberg
Member, General Division - Income Security