Citation: ***K. M. v. Minister of Employment and Social Development,*** **2015 SSTGDIS 51**

Date: June 1, 2015

File number: GT-121029

GENERAL DIVISION - Income Security Section

Between:

K. M.

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 April 7, 2015

REASONS AND DECISION

PERSONS IN ATTENDANCE

K. M., the Appellant
Zeeshan S. Baig, the Appellant's legal representative

INTRODUCTION

[1] The Appellant's application for a *Canada Pension Plan* (CPP) disability pension was date stamped by the Respondent on June 15, 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: Videoconferencing is available in the area where the Appellant lives; the issues under appear are not complex; and 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.

Preliminary Issue

[3] The Appellant filed an updated legal submission with attachments with the Tribunal on April 6, 2015 (GT-7). As the submission and attachments primarily consisted of existing medical reports, the Appellant's income tax returns and an explanation concerning her income, the Tribunal admitted GT-7 into evidence. A copy was sent to the Respondent to provide it with an opportunity to make comments, if any.

[4] On April 21, 2015, the Respondent advised the Tribunal by email that it would not review GT-7 since it did not appear to respond to the Respondent's submission and contained information that would have been available by the end of the Response Period.

THE LAW

[5] 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.

[6] 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).

[7] 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.

[8] 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

[9] There was no issue regarding the MQP because the parties agree and the Tribunal finds that the MQP date is December 31, 2000.

[10] 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 the MQP.

EVIDENCE

Documentary Evidence

[11] In the CPP Questionnaire dated June 1, 2011, the Appellant indicated she stopped working on October 1, 1997 for medical reasons. She had worked since February 1, 1981 as a sewing machine operator. The Appellant was born in 1956 and completed Grade 6.

[12] In the CPP Medical Report dated December 3, 2011, Dr. Syed, orthopedic surgeon, reported that the Appellant had right foot heel bursitis with ongoing pain in the right heel, right shoulder rotator tear and bilateral knee arthritis. He indicated she was receiving physiotherapy for the right shoulder and both knees. She had received an injection for heel pain and was using shoe modifications. He indicated she would likely have longstanding pain in the shoulder and knees.

[13] In the CPP Medical Report dated June 4, 2011, Dr. Choi, family physician, indicated he knew the Appellant since 1980 and had treated her main condition since May 2006. He diagnosed: hypothyroid, high blood pressure, degenerative disc disease of lumbosacral spine with herniated disc (2006), fibromyalgia, urine stress incontinence, anemia, degenerative arthritis both knees and left shoulder rotator cuff tear (September 2010). He described a total knee replacement in September 2009, arthroscopic surgery in June 2009, fibromyalgia in 2006, lumbosacral disc herniation in March 2006 and left shoulder rotator cuff surgery in September 2010. Under Physical Findings/Functional limitations, Dr. Choi described painful movements of knees, left shoulder and lumbosacral spine. The Appellant was prescribed Amitriptyline, Hydrochlorothiazide, Eltroxin, Tylenol 3 and Crestor. He stated she would soon undergo a right total knee replacement and was being investigated for anemia. She had 16/18 fibromyalgia tender points, decreased tolerance for walking and standing, decreased physical stamina and chronic pain with generalized fatigue.

[14] In a December 1, 1997 report, Dr. Logarakis, dictating for Dr. Hassouna, described a pubovaginal sling procedure performed due to the Appellant’s stress urinary/incontinence.

[15] On July 13, 1999, Dr. Lee, rheumatologist, saw the Appellant for worsening of discomfort in her right elbow and left shoulder and increased numbness in her right hand and more recently left hand. Dr. Lee stated: "In summary, (the Appellant) has exacerbation of her right lateral epicondylitis and left shoulder rotator cuff tendonitis. She also appears to have worsening of her carpal tunnel syndrome bilaterally". Dr. Lee suggested a cortisone injection to the left shoulder and right elbow, which the Appellant agreed to pursue. Dr. Lee further asked the Appellant to use a wrist splint for numbness in her hands.

[16] Dr. Choi referred to fibromyalgia in his June 20, 2000, July 11, 2000, August 28, 2000 and December 6, 2000 clinical notes. In his November 21, 2000 clinical note, he diagnosed degenerative disc disease.

[17] On June 20, 2000, Dr. Lee saw the Appellant for follow up of her left shoulder and neck discomfort. She had discomfort over her left trapezius and base of the neck. She also complained of bilateral numbness in her hands following carpal tunnel surgery. Dr. Lee stated: "In summary, **(**the Appellant) has chronic neck and left shoulder discomfort following a motor vehicle accident more than 10 years ago. I suspect that her current symptoms are the result of neck strain radiating to the trapezius muscle." Dr. Lee did not find significant abnormality in the rotator cuff except for some mild tenderness. On musculoskeletal exam, the Appellant had good range of movement of her neck with some stress pain and tenderness at the base of the left cervical spine and over the trapezius muscle. She also had good range of movement of both shoulders without much discomfort. She had mild tenderness in the lower lumbar spine, 12/18 tender points and good motor strength. Dr. Lee gave the Appellant a trial of cortisone injection to the trigger points along the trapezius muscle to provide relief of discomfort. She also encouraged her to consider attending a pain management clinic. According to Dr. Lee, the Appellant was not interested in pursuing this recommendation.

[18] According to a September 22, 2000 imaging report of the wrist, no evidence was seen of recent or remote fracture.

[19] An October 24, 2000 CT of the cervical spine revealed minimal degenerative cervical disc disease.

[20] A May 24, 2001 MRI of the left shoulder was unreadable. It was taken on account of a clinical history of rotator cuff tear.

[21] On November 5, 2001, Dr. Lee reported the Appellant was seen for left shoulder discomfort and that a left shoulder MRI (presumably referring to the May 24, 2001 MRI) demonstrated degenerative changes in the acromioclavicular joint with a small hook off the acromion, rotator cuff tendonosis with partial tearing of the supraspinatus and some degenerative change in the antero inferior labrum. The Appellant was having persistent and severe left shoulder pain with only temporary relief with cortisone injection. The Appellant agreed to pursue surgery and was placed on the list for a distal clavicular excision and subacromial decompression.

[22] According to a January 30, 2002 report of Dr. Miniaci, the Appellant had left shoulder pain "for quite some time now." It was on a constant basis and affected reaching for objects above the level of the shoulder or at arm's length. Dr. Miniaci indicated that the Appellant may benefit from surgery. On April 11, 2002, Dr. Bogoch placed the Appellant on the surgery list.

[23] On September 18, 2002, the Appellant underwent a left acromioclavicular joint decompression, resection distal clavicle and acromioplasty. On October 1, 2002, Dr. Bogoch reported the Appellant's rotator cuff was intact post-surgery. She started physiotherapy to mobilize her shoulder.

[24] On November 26, 2002, Dr. Stackpool, dictating for Dr. Bogoch, reported that the Appellant was progressing slowly post-surgery but was complaining of some persistent mild pain and shoulder stiffness. According to Dr. Bogoch, it would not be uncommon to have some postoperative pain, which he suspected would subside within six weeks.

[25] On January 7, 2003, Dr. Bogoch reported on the left shoulder post subacromial decompression surgery for the Appellant's impingement syndrome. He stated her shoulder pain seemed to be relieved. She could elevate her shoulder fully and had excellent rotation. She complained of some pain in the left trapezius area but he could not find anything in her neck, shoulder or trapezius. He advised her to discontinue therapy, try to return to normal activity and stated that the trapezius pain would subside.

[26] On June 23, 2003, Dr. Bogoch reported that the Appellant had good relief of her shoulder and arm pain following the September 2002 surgery. She could elevate her shoulder easily and her painful arc and impingement signs were gone. Dr. Bogoch indicated the Appellant was under the impression that the pain in the upper left trapezius area would be operated on. He explained to her that this was referred pain from her neck and not connected to the shoulder procedure. He stated that he would refer her to physiotherapy for her cervical spine.

[27] On October 9, 2003 Dr. Lee assessed the Appellant for bilateral knee pain worse on th**e** right side for one year. Dr. Lee stated: "In summary, Mrs. K. M. has a one-year history of right knee pain likely due to an anserine bursitis and possibly some early medical compartment arthritis". According to Dr. Lee, the Appellant had difficulty keeping the knee in a prolonged flexed position while sitting or sleeping. However, she had no limitation in walking. Dr. Lee suggested a trial of cortisone injection to the bursa.

[28] An October 26, 2004 imaging report revealed a history of trauma to the right 3rd finger and soft tissue swelling overlying the proximal interphalangeal joint of the right 3rd finger.

[29] On November 21, 2005, the Appellant was seen by Dr. Yu for assessment of chest pain of about six months duration. Dr. Yu recommended a stress echocardiogram. On January 30, 2006, the Appellant was further seen for some episodes of atypical chest discomfort. Based on her negative stress echocardiogram, Dr. Yu stated it was unlikely she had significant coronary artery disease. He suggested aspirin and elected to see how her symptoms progressed.

[30] A March 7, 2006 imaging report revealed mild localized degenerative disc disease at L4- L5.

[31] On May 16, 2006, Dr. Lee assessed the Appellant for low back pain of two months duration. She noted numbness over the lateral/anterior thigh, suspected meralgia paresthetica and diagnosed mechanical back pain likely due to degenerative disc disease. Dr. Lee recommended weight loss and an increase in Amitriptyline to help with the paresthesia. She also ordered a nerve conduction test. Dr. Lee indicated the Appellant also complained of some stiffness/heaviness in her right 2nd and 3rd digits at night for the past six months. She noted the Appellant underwent carpal tunnel surgery about five years earlier, queried whether there was a

worsening of the CTS and asked that the hand be assessed as part of the nerve conduction investigation.

[32] On May 23, 2006, the Appellant was assessed by Dr. Cooper, psychiatrist. She presented with anxiety, tension and complaints of forgetfulness. The problem had gotten worse the past year. According to Dr. Cooper, between 1981 and 1987, the Appellant worked as a machinist in a factory and "now works helping her husband on the farm..." Dr. Cooper did not find any evidence clinically that the Appellant was having problems with her memory. He indicated she did not appear to be clinically depressed and found no evidence of thought or perceptual disorder. Her memory and concentration appeared to be intact.

[33] On August 10, 2006, Dr. Kong saw the Appellant for a neurology consultation. According to Dr. Kong, the Appellant had numbness and tingling in her hands for two years. Dr. Kong stated the Appellant first developed bilaterally hand numbness over 10 years earlier and had a right carpal tunnel release surgery about 10 years earlier and the left side two years later. Her symptoms improved initially. Dr. Kong wrote: "For the last two years, she has had worsening bilateral hand numbness, affecting the palm and the first three digits…" Dr. Kong found clinical and electrophysiological evidence of mild bilateral CTS. He advised the Appellant to wear bilateral wrist splints at night. He also noted her complaint of "numbness and tingling in the right lateral thigh for the last three month". He queried a diagnosis of myalgia paresthetica or entrapment of the right lateral cutaneous nerve of the thigh. He stated the Appellant had a long history of widespread musculoskeletal type pain for over five years affecting the neck, lower back and all four limbs. He stated he understood this was attributed to fibromyalgia "in that she is on Amitriptyline". Dr. Kong reported that Tinel's sign was negative at both wrists and both elbows and that neither ulnar nerve was palpably enlarged.

[34] In September 2006, Dr. Lee saw the Appellant in follow up for her thigh numbness. The investigation, which included a nerve conduction test, was in keeping with meralgia paresthetica. Dr. Lee encouraged the Appellant to lose weight which might help with the nerve impingement. According to Dr. Lee, the Appellant was "resistant" to the idea of losing weight, stating that she lived a healthy lifestyle. She inquired into liposuction, which Dr. Lee ruled out.

[35] In September 2006, Dr. Almousa, dictating for Dr. Hassouna, reported that the Appellant was seen due to urinary dysfunction and leakage with moderate nocturia twice per night. She was diagnosed with stable compensated bladder with no evidence of any stress incontinence.

[36] On February 28, 2007, the Appellant was seen by Dr. Sharma in the neuromuscular clinic. Electrodiagnostic studies confirmed bilateral CTS which had worsened compared to an August 2006 study. There was no evidence of LS radiculopathy but S1 paraspinals revealed mild denervation consistent with underlying degenerative disease. Dr. Sharma stated: "(The Appellant) works on a farm growing vegetables. She reports that she will be starting a greenhouse soon in the next few weeks".

[37] An April 2007 CT of the lumbar spine revealed posterior-central disc herniation at the level of L4-5 with disc degeneration.

[38] According to the April 10, 2007 report of Doctors Anand and Cavalcanti, the Appellant was noted to have had chest pains since November 2005. A stress echo performed in December 2005 was normal. A MIBI in June 2006 showed a small reversible LAD territory defect which was considered low risk. A September 2006 angiogram showed normal coronary arteries. There was increase LVDP showing diastolic dysfunction but normal left ventricular ejection fraction.
The doctors noted she continued to have atypical chest pains associated with shortness of breath, nausea and palpitations consisting of 3-4 episodes per week and occurring on exertion or at rest.

[39] On September 11, 2007, Dr. Lee saw the Appellant for acute low back pain which started in January that year. According to Dr. Lee, the Appellant was in Mexico at the time doing a lot of walking and sightseeing. When she returned home, she started having pain in the low back and weakness down the leg. An April 30, 2007 CT of the lumbar spine revealed posterocentral disc herniation at L4-5 with disc degeneration and some compression of the thecal sac. On examination, she had good range of movement of her hips and knees. According to Dr. Lee, she suggested physiotherapy however the Appellant was reluctant to pursue it as she did not think it would be helpful. Dr. Lee indicated she would see the Appellant following an MRI of the back.

[40] On September 27, 2007, Dr. Ogilvie, clinical pharmacologist, reported on the Appellant's variable blood pressure over the last six months noting she was under considerable stress.

[41] On September 18, 2007, Dr. Zamel reported the Appellant's pulmonary function test was essentially normal with only borderline low flows.

[42] On October 23, 2007, the Appellant was seen at the Respirology Clinic for right pleural effusion. According to Dr. Levitt, it appeared her pleural effusion (which had first been identified on April 10, 2007) had resolved.

[43] In October 2008, Dr. Ghazwani, dictating for Dr. Hassouna, reported that the Appellant required a cystoscopy and video urodynamic study. According to the November 6, 2008 urodynamic study and cystoscopy, the Appellant had an unstable urethra with no evidence of obstruction. She was given anticholinergics to cope with her incontinence and was scheduled for review in six months.

[44] On November 4, 2008, Dr. Sussman reported that the Appellant presented with pain in the left knee. There was mild narrowing in the joint compartment and in the patellar femoral joint consistent with mild degenerative change.

[45] On November 25, 2008, Dr. Lee saw the Appellant for low back and left knee pain which flared up on October 11, 2008. She had pain if standing more than two hours or walking more than an hour but had no difficulty sitting down. According to Dr. Lee, the low back pain was on an intermittent basis. It was usually worse when getting up. The Appellant could walk for one or two hours and was more limited by knee pain than the back. She had occasional radiation down the left leg of about two years duration. However, the Appellant's main concern was her left knee with acute pain. Dr. Lee suspected a flare of knee arthritis or a meniscal tear. Dr. Lee also noted some features of fibromyalgia and suggested some pool therapy.

[46] On January 20, 2009, Dr. Lee saw the Appellant for follow up of her left knee pain. She reported that while on holiday the previous month, the Appellant developed sharp pain in the left knee while on a walking tour. She could only walk for 10 minutes. On examination, the knee had

full range of movement with pain. The Appellant had a positive McMurray's test for medial meniscus. Dr. Lee suspected a torn left medical meniscus.

[47] A June 2009 MRI of the left knee revealed a complex tear involving the posterior horn of the medial meniscus.

[48] On June 5, 2009, Dr. Syed reported that the Appellant was seen for left knee pain during the previous five months. She could not walk. Given the MRI test results, Dr. Syed recommended arthroscopy. On June 18, 2009, Dr. Ali saw the Appellant for follow up of her left knee arthroscopy performed seven days earlier. Her range of motion was full and postoperative pain was improved.

[49] On October 8, 2009, the Appellant was seen in follow up for her left total knee arthroplasty performed in September 2009. She was complaining of pain. She was further seen in follow up in December 2009 still complaining of pain but to a lesser degree. Dr. Syed explained that the left knee stiffness was related to scar tissue and asked the Appellant to start aggressive range of motion therapy of the left knee for two months. If the outcome was poor, he would schedule debridement and manual manipulation of the left knee.

[50] On February 26, 2010, Dr. Syed reported that the Appellant had a left total knee arthroplasty in September 2009. She was last seen in January 2010 having increasing pain in the medial and lateral aspect of her joint. On examination, she had mild effusion, tenderness on palpation and reduced range of motion. As her mobility had not improved and pain had increased, Dr. Syed discussed the possibility of performing a knee arthroscopy and manual manipulation. On March 4, 2010, the Appellant underwent arthroscopy. According to a March 22, 2010 report of Dr. Hassouna, the Appellant felt better. She had increased range of motion but was still complaining of pain anteriorly in the left knee. She was advised to continue physiotherapy and encouraged to increase her range of motion.

[51] On March 22, 2010, the Appellant was seen following the left knee arthroscopy for stiffness. According to Dr. Hassouna, the Appellant felt better and had increased range of motion but was still complaining of pain in the left knee and was taking six Percocet a day. She had pain

on palpation and a mild effusion. She was advised to continue physiotherapy and encouraged to increase her range of motion with home exercises.

[52] On April 9, 2010, the Appellant underwent percutaneous nerve stimulation to determine whether she was a good candidate for a neurostimulator implant in relation to her voiding dysfunction. On April 14, 2010, she reported a good response in reduction, frequency and urgency of voiding. On August 24, 2010, she underwent surgery for permanent insertion of a neurostimulator. In March 2011, she underwent relocation surgery after experiencing pain at the site of the neurostimulator implant battery.

[53] Dr. Syed saw the Appellant on April 26, 2010 in follow up to her left knee arthroscopy. She complained of pain during the previous two weeks and limited range of motion. Before then, she had achieved good range of motion up to 95 degrees by herself. Physical examination revealed mild swelling with range of motion from 5 to 90 degrees. Dr. Syed recommended continued physiotherapy with manual therapy to increase range of motion.

[54] On June 7, 2010, Dr. Syed saw the Appellant in follow up for her left knee replacement. She had some stiffness and better range of motion. She was told to perform aggressive physiotherapy. She was further seen on June 14, 2010. She had stiffness with range of motion 0 to 90 degrees. Dr. Syed performed manipulation under sedation.

[55] On June 28, 2010, Dr. Syed saw the Appellant. She continued to complain of pain on the anterior aspect of the left knee. She also complained of right ankle pain on the lateral and medial aspect. Physical exam of the right ankle showed swelling and tenderness on the lateral and medial aspect. Dr. Syed indicated possible ligamentous injury of the right ankle and recommended caste immobilization.

[56] On July 14, 2010, the Appellant was seen in follow-up for her left knee condition. She had stiffness and range of motion from 0 to 90 degrees.

[57] On July 2, 2010, Dr. Syed reported that the Appellant continued to complain of pain. She had limited flexion. He performed submaximal manipulation and another knee scope. On July 19, 2010 Dr. Syed reported that the Appellant continued to complain of pain in the medial and lateral aspects of the left knee. His impression was one of limited flexion. He performed

submaximal manipulation and opted for another knee scope and stated: “This is a 54-year-old with limited flexion of the knee after total knee replacement in September 2009”.

[58] On August 18, 2010, the Appellant was seen by Dr. Davey on behalf of Dr. Yu, for episodes of chest pain and shortness of breath especially when walking outside. She was noted to have had a recent negative coronary catheterization in 2006 and Persantine MIBI before that which showed some small reversible defect ion the LAD distribution. Possible diastolic dysfunction was noted on her catheterization report. She had an ECG which revealed normal sinus rhythm. She was sent for a Dobutamine stress echo test. On October 21, 2010, Dr. Yu reported the Appellant underwent a perfusion scan which was normal. She still had symptoms of shortness of breath but was not experiencing chest discomfort. Dr. Yu referred her to a respirologist as he doubted her symptoms were cardiac in nature.

[59] On September 2, 2010, Dr. Rajamanickam writing for Dr. Syed, reported that the Appellant’s left knee was not moving well. She had undergone MRIs of the right ankle and left shoulder. The left shoulder MRI revealed tendinopathy of the supraspinatus with articular surface tear partial. Dr. Syed offered a subacromial decompression plus or minus rotator cuff repair at the same time as knee manipulation. The MRI did not show anything of note in relation to the left ankle, which Dr. Syed injected with cortisone for possible bursitis/inflammation along the lateral aspect.

[60] On October 1, 2010, the Appellant underwent left knee arthroscopy, debridement, rotator cuff repair (revision), bursectomy left shoulder, arthrotomy left shoulder joint, biceps tendon repair. Under the heading ‘Clinical Note’, the following entry was made: “This lady has had pain in the left shoulder and left knee. She has had previous left shoulder surgery about 10 years ago. She gradually developed pain again”.

[61] On October 14, 2010, the Appellant saw Dr. Syed following her left knee scope and left shoulder rotator cuff repair. He advised her to start physiotherapy for the left shoulder.

[62] On October 21, 2010, the Appellant was seen in follow up by Dr. Yu for episodes of “atypical chest discomfort, particularly when she was walking around in her greenhouse last summer.” He reported that the Dobutamine stress echocardiogram did not reveal any wall motion

abnormalities and that the September 2010 perfusion scan was normal. She continued to have symptoms of shortness of breath but no episodes of chest discomfort. Her blood pressure was 120/80. He queried a pulmonary component to her shortness of breath and referred her to a respirologist.

[63] A February 2011 MRI of the lumbar spine revealed mild degenerative changes of the lumbar spine, with a diffuse disc bulge at L4-5 touching the descending right L5 nerve root and slightly impinging the exiting L4 nerve roots bilaterally.

[64] On April 8, 2011, Dr. Syed saw the Appellant for her right and left knee pain. He noted she had a left total knee replacement in September 2009 and a scope for total knee stiffness in September 2010. She was happy with the range of motion improvement but complained of pain on the anteromedial aspect of the left knee. She also complained of right knee pain with swelling for which she had a right knee scope in 2009. She was noted to have difficulty using stairs. Dr. Syed explained that the left knee pain was related to tendonitis and that the Appellant required exercise and physiotherapy. He discussed a possible total knee replacement for the right knee.

[65] On May 2, 2011, Dr. Syed diagnosed i) left total knee replacement with residual stiffness;
ii) right knee osteoarthritis, awaiting total knee replacement; and iii) radiculopathy, awaiting nerve root injection He recommended physiotherapy for the left knee and a total knee replacement for the right knee.

[66] On May 27, 2011, the Appellant was seen by Dr. Varadi for exertional dyspnea. Its etiology was unclear. Pulmonary function tests showed only mild proportional reduction in flows with otherwise normal lung capacity.

[67] According to a September 2011 MRI of the shoulder, there was previous resection of the distal clavicle. There were mild osteoarthritic changes within the glenohumeral joint and degenerative enthesopathy at the superior aspect of the greater tuberosity.

[68] According to a February 2011 MRI Lumbar Spine, the Appellant had mild degenerative changes of the lumbar spine with a diffuse disc bulge at L4-5, touching the descending right L5

nerve root and slightly impinging the exiting L4 nerve root bilaterally. In February 2011, the Appellant underwent a right L4 nerve root injection.

[69] A May 2011 preadmission report referred to moderate osteoarthritis of the patellofemoral joint compartment.

[70] According to the June 2011 report of Dr. Naraghi, the Appellant underwent right total knee arthroplasty with patellar resurfacing. Position and alignment of the metal work was unremarkable.

[71] According to a June 2011 Bilateral Lower Limb Venous Doppler, no deep vein thrombosis was found above the right calf.

[72] On July 25, 2011 Dr. Syed reported he saw the Appellant for bilateral total knee arthroplasty follow up. Her left knee was done a few years earlier and the right knee on June 15, 2011. She was doing very well. The right knee had range of motion from 0-115 and left knee had 0-100 degrees. Dr. Syed wanted her to continue with physiotherapy with range of motion and strengthening exercises.

[73] A September 19, 2011 foot/ankle radiology report revealed no acute bony injury and bony alignment of the right and left ankles. A September 29, 2011 shoulder x-ray revealed mild osteoarthritic changes within the glenohumeral joint and degenerative enthesophathy at the superior aspect of the greater tuberosity.

[74] On November 11, 2011, Dr. Syed diagnosed: i) bilateral total knee arthroplasties; ii) right foot ganglion, iii) right plantar fasciitis; and iv) right rotator cuff repair. He offered the Appellant an injection of the ganglion cyst.

[75] On December 13, 2011, Dr. Syed saw the Appellant for her left shoulder. She continued to have pain and limited range of motion. He gave her a cortisone injection.

[76] The Appellant saw Dr. Johnson on March 16, 2012 for left shoulder pain and instability. He recommended physiotherapy and range of motion exercises for biceps and muscle strengthening exercises and local cortisone injections for pain.

[77] On December 11, 2012, Dr. Lee reported to Dr. Choi on the Appellant's fibromyalgia. She noted the Appellant required surgery in 2000 for her left shoulder and underwent a revision in 2010. According to Dr. Lee, for the past year, the Appellant had been experiencing low back pain requiring injections on several occasions. The pain since moved to the left side. She also underwent bilateral knee replacement in 2009 and 2010. Her main concern at the time of consultation was difficulty sleeping and non-restorative sleep. According to Dr. Lee, the Appellant had generalized musculoskeletal pain with poor nonrestorative sleep. Dr. Lee also described a history of longstanding fibromyalgia. On January 23, 2013, Dr. Lee reported that in the past two weeks, the Appellant had swelling on the left side of her face. She indicated the Appellant had swelling of the face for many years mostly on the right side but that previous investigations were normal. Dr. Lee noted a good response to Lyrica.

[78] On February 7, 2013, the Appellant saw Dr. McCabe for her longstanding history of bilateral CTS. According to Dr. McCabe, the Appellant had carpal tunnel release about 10 years earlier. He stated: "Currently, she has symptoms which are constant in the medial nerve distribution". Dr. McCabe elected to proceed with electrodiagnostic testing and injection of the right carpal tunnel.

[79] On February 25, 2013, Dr. Syed saw the Appellant for shoulder pain. She was neurovascularly intact. He gave her a cortisone injection and advised her that she could continue with activity as tolerated.

[80] On June 13, 2013, Dr. Syed saw the Appellant for left shoulder pain radiating to her neck. He stated she had surgery in the past which gave her "significant" relief. However, she recently developed some inflammation in the shoulder which was bothering her. He injected her with cortisone and recommended rehabilitation.

[81] On July 3, 2013, the Appellant saw Dr. Lee for fibromyalgia. She had a sleep study which did not find any evidence of sleep apnea but moderate Alpha EEG disorder. Her condition was relatively stable and she did not require follow up.

[82] On May 26, 2014, Dr. Syed responded to the Appellant's counsel's request for a report. Dr. Syed stated that the Appellant suffers from multiple joint arthritis which affects her

shoulders, knees and spine. She had a left knee replacement and both shoulders were decompressed. Her right knee arthritis was being managed with anti-inflammatories and injections and she would likely require knee replacement surgery in the future. Dr. Syed stated: "Currently, her right knee does limit her ability to walk and stand". She also had surgery on both shoulders but has ongoing pain and requires cortisone injections. The shoulder pain limits her ability to use her arms to carry objects or do any activity at the shoulder level or above shoulder level. She also has chronic back pain managed by therapy and injections. It limits her ability to stand, walk and sit for prolonged periods of time".

[83] On June 11, 2014, the Appellant's counsel reported that the Appellant was diagnosed with diabetes and was referred to the Diabetes Education Program.

Oral Testimony

[84] The Appellant is age 58. She was born in X, South America.

[85] She came to Canada in 1980 with her spouse and two children.

[86] She currently lives alone in X.

[87] She last worked in 1997.

[88] She stopped working due to bladder surgery as she could not hold her urine. She never returned to work after this. Her husband got a farm and she would help out, i.e., she would supervise workers as she could not do the work.

[89] After 1997, she was in pain and could not do much. At the farm, she would help by opening the Greenhouse and turning on the fan and showing workers where to find things. It was not paid work. Her husband ran the business and her name was not on title to the farm business. Her husband did not provide her paychecks.

[90] She never returned to work after surgery in 1997. She had shoulder surgery in 2001 and could not do much with her shoulder after that. She could not lift anything. She then had knee pain. She got serious about her knee condition in or around 2005 when she starting seeing doctors.

[91] The knee condition stopped her from doing too much on the farm. She also had problems with her shoulder and back which restricted her on the farm.

[92] She had lots of back pain. Between 1997 and 2000 she was in pain. She could not lift her shoulder. She also had lots of numbness in both hands. She had CTS surgery on both hands and nerve tests at Toronto Western Hospital. The doctors told her she had CTS and required surgery. It was sometime in the 2000s.

[93] Dr. Choi has been her family doctor since 1980. She still sees him. He referred her to Dr. Mary Lee, who sent her for shoulder surgery and treated her knee. She started seeing Dr. Lee during the 1990s. Dr. Lee gave her cortisone injections for shoulder pain. The Appellant also went for therapy in X following shoulder surgery in 2000 or 2001. Prior to surgery, she had tried injections.

[94] She had an accident in 1991, which is when a lot of her problems started including her shoulder and back pain.

[95] She may require further shoulder surgery.

[96] She had left knee surgery. She still had pain and had a left knee replacement. She also had a third surgery on the left knee. She also underwent right knee replacement.

[97] In terms of her urinary problems, she took tablets which got expensive. She then got an implant to control her urine. It has improved her situation by 75%. The implant bothered her as she could feel it in her buttocks while sitting. They implanted a smaller device within her body.

[98] She has lost some weight. She would go to the gym and stay about one hour. She could not push herself due to her knee and shoulder pain. She also lost some weight due to stress. Following the 1997 surgery, she had a “tummy tuck” due to an overhanging stomach, in order to feel better.

[99] Her family doctor told her she has had arthritis over 10 years ago or more. It goes back to 2000 when Dr. Lee treated her for this. She said she could not sleep at night and was given Lyrica.

[100] She takes Tylenol 3 for pain, Amitriptyline for sleep, Lyrica, Celebrex, a sugar tablet for diabetes (diagnosed one year ago), aspirin, Synthroid for her thyroid condition and medication for high cholesterol. They are prescribed by Dr. Choi and Dr. Syed, her surgeon.

[101] She once saw a psychiatrist. They discussed her memory loss and lack of sleep. Her lawyer referred her to the psychiatrist. She cannot recall when she saw him. The referral helped a little. She does not currently see the psychiatrist.

[102] She is depressed and had a sleep apnea test to find out why she cannot sleep. The pain affects her sleep. The Amitriptyline does not always help. Some nights, she stays up until 5:00 am. She does not keep track how often it happens. It could happen a couple times a week.

[103] She is divorced and lives alone in a townhouse where she has resided since 2011.

[104] She worked on the farm after 1997 until she had so much pain she could no longer do so. She would supervise people and show them what to do. Despite her income tax information which indicates she earned $2,149.00 in 2006, she does not recall earning this. An accountant did her taxes. She never saw a cheque in this amount. She did not work at the farm in 2006/2007.

[105] In terms of income showing on her income tax returns for 2011 and 2012, these amounts were paid by London Life for a retirement pension on account of the sewing machine operator job where she worked between 1981 and 1997. When she turned 55, they told her she could receive the money. She receives a monthly deposit into her banking account. She also receives a Trillium benefit about once every six months.

[106] She had a carpal tunnel procedure last year. Her hand is still numb. She cannot open her right hand. It is swollen. She is awaiting further surgery.

[107] Her chest pain started in or around 2005. She felt dizzy and collapsed.

[108] She has problems with her left heel. The problems started around 4 years ago. The doctors said she had a spur. She has had cortisone injections.

[109] She has had hypothyroidism for about 15 years. The doctors found a little lump in the throat. They told her she did not require surgery. Sometimes, she loses her voice for several

hours. The doctors have told her she will be ok in a couple of days. Dr. Choi increased her medication.

[110] Dr. Choi and Dr. Syed told her that her knee would get worse.

[111] She has pursued all treatments.

[112] She cannot stand for two hours. Her heel hurts. She cannot pick anything up. Her arms are numb. She has problems with her shoulder. She cannot bend due to her knees. She cannot sit for long. Before 2000, there was no job she could do.

[113] She has little education. She went to school at Yonge and Highway 7 for less than one year in 2013 until her son passed away. She learned basic information, e.g., how to read and write and use the computer. Since her son's death, she has been unable to pursue this. She does not believe that if she finished the program, she could get a job. Her pain does not allow her to work. She cannot say whether she hoped she would able to get a job in 2013.

[114] She never worked in X. She only worked as a sewing machine operator in Canada for 17 years. She could not do this now. She never looked for similar work. Following surgery, she could not do much.

[115] In response to questions from the Tribunal, the Appellant clarified she attended school in 2013 between March and December. She attended 3 days weekly between 8:00 a.m. and 12:00 p.m. There was one half-hour break. If she needed to stretch or walk, she was free to do so. She would go on the computer and pursue other activities such as answering questions on the chalkboard. She was not sitting in one place all the time. She would drive to school. It would take between one-half hour and 45 minutes. She would leave home early to avoid traffic because she cannot sit long. The ride home was of similar duration.

[116] After she felt better following her 1997 surgery, she had acted as a supervisor on the farm. She worked on the farm between approximately 2003 and 2006 at which time she "started with the knee". Her work on the farm consisted of opening the greenhouse and turning on the fan during a six week period between April and May. She would also supervise workers if they

sought instructions. She might do this approximately several times a week and show them where equipment was.

[117] In response to the Tribunal's question whether she ever performed other activities on the farm, she stated that she would sit and place plants in a cup, which a machine would then plant. She might do this between one-half and one hour.

[118] She took issue with Dr. Lee's comments in her June 2000 report that she was not interested in pursuing a pain management program. She stated Dr. Lee sent her for therapy and that she received cortisone injections. She attended X Recovery Clinic and a clinic on Wellington for therapy three times weekly.

[119] In terms of Dr. Lee's comment in her September 2006 report that the Appellant was resistant to losing weight, the Appellant denied this. She stated she would do whatever her doctors told her.

[120] In terms of Dr. Lee's September 2007 report indicating the Appellant was in Mexico doing a lot of walking and sightseeing, the Appellant stated she was in pain and could not walk. The Tribunal reminded the Appellant Dr. Lee indicated she only started having pain in the low back and weakness down the leg after she returned home. The Appellant reiterated she could not walk on the trip. The Tribunal then referred the Appellant to Dr. Lee's January 2009 report, in which she indicated the Appellant developed sharp pain in the left knee while on a walking tour and asked her to comment. She replied she could not recall anything about that trip.

[121] On re-examination, the Appellant clarified she attended school between March and December 2013 and stopped attending when her son died. She was stressed. She also had diabetes and problems with her neck. She could not sit.

[122] The plantar machine on the farm would move through rows in the field. If someone was late for work, she would fill in for that worker. They would not be late too often and rarely more than 45 minutes to one hour.

[123] Her husband planned the trip to Mexico. She couldn't get off the bus and walk on the tour. She recalls going to X in October 2009 when her brother died. She does not recall going to Mexico in December 2008. She did not see Dr. Lee for a long time after she had surgery.

SUBMISSIONS

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

a) She suffers from a multitude of conditions (see Appellant's written submission at GT2)

b) She has experienced pain in her left trapezius and base of neck following a 1991 Motor Vehicle Accident (MVA). She missed over two years work. She developed problems of low back pain, knee pain, metacarpal tunnel syndrome, shoulder pain, depression, etc., as a result of the MVA.

c) She is totally incapable of performing any kind of modified or full-time duties in the work force a result of her fibromyalgia, left shoulder pain (for which she will undergo another surgery in the near future), depression/anxiety, numbness of both arms and severe low back pain. She cannot use her left shoulder or arm due to pain and numbness. She drops things from her left hand. She also experiences chest pain.

d) Her work on the farm was not gainful.

e) Her income from London Life is not derived from gainful employment.

f) All of her income information was below the 'Low-Income Cut Offs'.

g) Although there is a seemingly marked disagreement between the professionals when her diagnosis of fibromyalgia first occurred, it cannot be said that a progressive disability such as chronic pain syndrome or fibromyalgia "first occurred only when some medical practitioner actually put a name on it. All of the evidence must be looked at by the Board to make its decision of the date of onset".

h) Fibromyalgia is first mentioned in Dr. Choi's June 20, 2000, July 11, 2000, August 28, 2000 and December 6, 2000 notes. The first diagnosis of degenerative disc disease is mentioned in Dr. Choi's November 21, 2000 notes.

i) While suffering from fibromyalgia and degenerative disc disease, she has also suffered from numerous other diagnoses which complicate these conditions and keep her incapable of pursuing any substantially gainful occupation.

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

a) According to the June 4, 2011 family physician's report, she had arthroscopic surgery of the left knee in June 2009 and a total knee replacement in September 2009. She was diagnosed with fibromyalgia in 2006. She was also found to have low back disc herniation in May 2006 and underwent rotator surgery in September 2010. These dates do not support a severe and prolonged disability when she last qualified in December 2000;

b) Due to discomfort related to pain in the neck and shoulder, Dr. Lee offered referral to a chronic pain management clinic. The Appellant declined indicating she was not interested. She has unreasonably refused to undergo recommended treatment.

c) The May 2006 rheumatology report noted the onset of low back pain two months earlier and confirmed meralgia paresthetica. This information does not support a severe and prolonged disability at the MQP.

d) The June 28, 2010 rheumatology report diagnosed right ankle pain. This was after the MQP;

e) The orthopaedic surgeon's September 2, 2010 report concerning the left shoulder revealed inflammation of a tendon and a partial tear. These problems arose after the MQP.

f) The cardiologist's October 21, 2010 report diagnosed atypical chest discomfort since the previous summer. This is after the MQP.

g) The orthopaedic surgeon's December 3, 2011 medical report diagnosed right foot heel bursitis, a right rotator cuff tear and bilateral knee arthritis. He anticipated longstanding pain in the shoulder and heel. These diagnoses were made after the MQP.

h) The information does not support a finding that hypothyroidism, high blood pressure or urinary stress incontinence prevent her from working.

i) She developed several medical conditions recently, none of which were actively treated in December 2000. She had surgery to the left shoulder in 2002 which was deemed to be successful relieving her pain and increasing her range of motion. Although she continues to have some issues related to stress incontinence or overactive bladder, this was surgically corrected in 1997 and caused no problems until 2008 onward. Also, this is not disabling and would not impede her ability to work in a suitable capacity.

j) Her other conditions of fibromyalgia, non-cardiac chest pain, knee and low back pain were all diagnosed long after she last qualified for disability benefits.

ANALYSIS

[126] The Appellant must prove on a balance of probabilities that the Appellant had a severe and prolonged disability on or before December 31, 2000.

Farm Work

[127] The Tribunal accepts the Appellant's testimony that the work she performed on the farm between approximately 2003 and 2006 did not reflect capacity regularly on her part to perform a substantially gainful occupation either in terms of her earnings or the limited and intermittent

nature of the work performed, e.g. opening up a greenhouse and turning on a fan, showing farm laborers where to get equipment, and infrequently sitting in for late workers on a planting machine for less than one hour.

2011/2012 Income/Earnings

[128] The Tribunal further accepts the Appellant's unchallenged testimony that the income attributed to her in 2011 and 2012 was pension income received on account of her previous sewing machine operator job and not on account of recent earnings.

Treatment Recommendations

[129] Although the medical record raises some question whether the Appellant was compliant with her doctor's recommendations (e.g., attending a pain clinic or losing weight), the Tribunal is satisfied, on balance that the Appellant pursued her doctors' treatment recommendations and has been compliant with treatment, including undergoing surgery on multiple occasions.

Medical Conditions

i) Left Shoulder/Neck pain

[130] The Tribunal is satisfied the Appellant had problems with her left shoulder condition on or before the MQP. For example, on July 13, 2009, she saw Dr. Lee, rheumatologist, for a number of problems including her left shoulder rotator cuff tendonitis. She also saw Dr. Lee on June 20, 2000 for follow up of her left shoulder and neck discomfort over the left trapezius and base of neck. Dr. Lee stated the Appellant had chronic neck and left shoulder discomfort following an MVA more than 10 years earlier and suspected her symptoms were the result of neck strain radiating to the trapezius muscle. However, she had good range of movement of her neck with some stress pain and tenderness at the base of the left cervical spine and trapezius muscle and good range of movement of both shoulders without much discomfort. Dr. Lee injected the trigger points along the trapezius muscle and encouraged the Appellant to consider attending a pain management clinic. Based on Dr. Lee's examination findings, the Tribunal is

unable to conclude that the Appellant's left shoulder/neck condition was severe as defined in the CPP at the MQP.

[131] The Tribunal remains fully cognizant of the fact an MRI taken shortly after the MQP, i.e., May 24, 2001, revealed degenerative changes in the acromioclavicular joint with a small hook off the acromion, rotator cuff tendonosis with partial tearing of the supraspinatus and some degenerative change in the labrum. The Tribunal is satisfied the evidence supports a finding that sometime after the MQP, the left shoulder condition became functionally impaired. As noted by Dr. Miniaci in his January 30, 2002 report, the Appellant's shoulder pain was constant and affected reaching for objects above the shoulder level at arm's length. This description of restriction twelve months after the MQP is markedly different than the one provided by Dr. Lee in June 2000 approximately six months prior to the MQP.

[132] If the Tribunal is mistaken in its view that the Appellant's left shoulder condition was not severe at the MQP, in any event, the Tribunal finds that this condition was not prolonged.

[133] According to Dr. Bogoch's January 7, 2003 post- surgery report, the Appellant underwent subacromial decompression surgery for impingement syndrome. Her shoulder pain seemed to be relieved. She could elevate her shoulder fully and had excellent rotation. Although the Appellant continued to complain of some pain in the left trapezius area, Dr. Bogoch could not find anything in her neck, shoulder or trapezius, advised her to discontinue therapy and try to return to normal activity. Dr. Bogoch further noted in his June 23, 2003 report that the Appellant could now elevate her shoulder easily and that her painful arc and impingement signs were gone. He further noted that her upper left trapezius area pain was referred from her neck and that he was sending her to physiotherapy.

[134] Given the excellent outcome of decompression surgery described by Dr. Bogoch, the Tribunal is not satisfied that the Appellant's left shoulder condition was prolonged, i.e., that it remained continuously severe following the MQP given the excellent results obtained from surgery.

[135] Although the Appellant continued to experience some pain in the left trapezius following surgery referred from her neck, the Tribunal is not convinced that the left trapezius

pain was sufficiently functionally disabling post-surgery that it prevented her regularly incapable of pursuing any substantially gainful occupation after the MQP.

[136] Following the excellent post-surgical results to the left shoulder, there exists a dearth of medical reports detailing significant problems with the left shoulder until long after the MQP. For example, on September 2, 2010, Dr. Rajamanickam, writing for Dr. Syed, reported that a recent MRI of the left shoulder revealed tendinopathy of the supraspinatus with articular surface tear partial. Dr. Syed offered the Appellant a subacromial decompression plus or minus rotator cuff repair. On October 1, 2010, she underwent a rotator cuff repair (revision), bursectomy left shoulder, arthrotomy left shoulder joint and biceps tendon repair. According to a clinical note, she had pain in the left shoulder with surgery about 10 years earlier but had "gradually" developed pain again.

[137] In conclusion on this point, although the evidence supports a finding the Appellant suffered recurrence of serious and significant problems and restrictions in her left shoulder necessitating surgery in October 2010, the Tribunal finds the onset of such recurrence was after the MQP.

ii) **Depression/Anxiety**

[138] The Tribunal has not been provided with any medical evidence that the Appellant was diagnosed with and treated for depression/anxiety on or before the MQP and that such conditions rendered her incapable regularly of pursuing any substantially gainful occupation.

[139] In his May 23, 2006 psychiatry report, Dr. Cooper reported that the Appellant did not appear to be clinically depressed. Although the Appellant's main complaint was one of forgetfulness, Dr. Cooper found that her memory and concentration appeared to be intact.

[140] The Tribunal is not satisfied that the Appellant suffered from depression/anxiety or significant memory problems on or before the MQP which were severe as defined in the CPP.

iii) **Severe Low Back Pain**

[141] In his August 10, 2006 report, Dr. Kong reported that the Appellant had a long history of widespread musculoskeletal type pain for over five years affecting the neck, lower back and

all four limbs. The Tribunal notes, however, that the medical record contains a dearth of medical reports addressing the low back condition and all four limbs on or before the MQP. The Tribunal has already addressed the left upper shoulder above. On June 20, 2000, Dr. Lee described only mild tenderness in the lower spine.

[142] The Tribunal finds the weight of the medical reports supports a finding of onset of low back problems after the MQP. For example, on May 16, 2006, Dr. Lee assessed the Appellant for low back pain with a duration of the previous two months. On September 11, 2007, Dr. Lee saw the Appellant for acute low back pain which started in January of the same year. An April 2007 revealed a disc herniation and some compression of the thecal sac.

[143] On balance, the Tribunal is not satisfied that the Appellant's low back condition was severe as defined in the CPP on or before the MQP.

iv) **Fibromyalgia**

[144] The Tribunal has not been provided with any contemporaneous reports on or before the MQP which clearly established not only a diagnosis of fibromyalgia but also related functional non-employability due to widespread bodily pain. The passing reference to fibromyalgia in Dr. Choi's sparse clinical notes in 2000 and Dr. Lee's passing reference to 12/18 tender points in her June 2000 report, do not persuade the Tribunal that the Appellant's fibromyalgia was severe as defined in the CPP on or before the MQP. In terms of Dr. Lee's June 2000 report, she did not state that the Appellant could not work. However, she did note good range of movement of the neck with some stress pain and tenderness at the base of the left cervical spine and over the trapezius muscle and good range of movement of both shoulders without much discomfort and only mild tenderness in the lower spine.

[145] As previously noted, on August 10, 2006 Dr. Kong indicated a long history of widespread musculoskeletal type pains for over five years affecting the neck, lower back and all four limbs, which he understood were attributed to fibromyalgia based on the fact the Appellant was on Amitriptyline. The Tribunal notes that a period of five years prior to August 2006 takes one to August 2001 and not December 31, 2000 - the MQP. The timeframe contemplated by Dr. Kong in his reference to "for over five years" is unclear.

[146] In her November 25, 2008, Dr. Lee, rheumatologist, saw the Appellant for her low back and left knee pain. She noted “some features” of fibromyalgia and suggested some pool therapy. Significantly, this rheumatology report created long after the MQP does not establish a clear and unequivocal diagnosis of fibromyalgia in 2008, let alone at the MQP. The Tribunal has addressed low back pain above and will address left knee pain below.

[147] In her December 11, 2012 report, Dr. Lee described a “history of longstanding fibromyalgia.” It is not clear whether Dr. Lee was referring to her November 2008 report in which she noted features of fibromyalgia as opposed to her June 2000 report in which she noted 12/18 tender points.

[148] The Tribunal is not persuaded that Dr. Kong’s 2006 reference to widespread musculoskeletal type pains, Dr. Lee’s noting of some features of fibromyalgia in 2008 and her 2012 comments about a history of longstanding fibromyalgia support a finding that the Appellant suffered from a severe disability as defined in the CPP on account of fibromyalgia at the MQP and continuously after.

v) **Knee pain**

[149] The Tribunal is not satisfied that the Appellant’s knee pain was severe as defined in the CPP on or before the MQP.

[150] There exists a dearth of evidence in the medical record concerning the Appellant’s knee condition on or before the MQP. The evidence all points to the onset of this condition after the MQP.

[151] On October 9, 2003, Dr. Lee saw the Appellant for assessment of bilateral knee pain worse on the right side for one year and stated: “In summary, (the Appellant) has a one-year history of right knee pain likely due to an anserine bursitis and possibly some early medical compartment arthritis.” Dr. Lee suggested a trial of cortisone injection to the bursa. On September 11, 2007, Dr. Lee saw the Appellant for an episode of acute low back pain. On examination, she noted the Appellant had good range of movement of her hips and knees. Then, on November 4, 2008, Dr. Sussman reported that the Appellant presented with pain in the left knee. That same month, Dr. Lee saw the Appellant for low back and left knee pain which flared

up on October 11, 2008. Dr. Lee suspected a flare of knee arthritis or a meniscal tear. In January 2009, Dr. Lee saw the Appellant, who reported she developed sharp pain in the left knee the previous month while on a walking tour. A subsequent MRI revealed a complex tear involving the meniscus. The Appellant subsequently underwent a total left knee arthroplasty in September 2009 and an arthroscopy in March 2010. However, she continued to complain of pain and stiffness. She also developed problems in the right knee. In April 2011, Dr. Syed reported complaints of right knee pain with swelling and noted an earlier right knee scope in 2009. He discussed a possible total knee replacement.

[152] Although the medical reports support a finding that the Appellant went on to develop significant problems with the left and right knees, the Tribunal concludes the onset is after the MQP.

vi) **Carpal Tunnel Syndrome (CTS)**

[153] The medical records support the existence of bilateral CTS prior to the MQP. For example, on July 13, 1999, Dr. Lee noted that the Appellant had worsening of her CTS bilaterally. She recommended a wrist splint for numbness in the hands. On June 20, 2000, Dr. Lee reported that the Appellant complained of bilaterally numbness in her hands even after CTS surgery.

[154] Apart from the above report, there exists a dearth of medical reports addressing CTS at the MQP date and continuously thereafter. Therefore, the Tribunal has reviewed the broader medical record in assessing the severe and prolonged nature of this condition. In doing so, it has arrived at the conclusion that the CTS was not severe and prolonged at the MQP and continuously thereafter.

[155] On August 10, 2006, Dr. Kong reported to Dr. Lee concerning the worsening of bilateral hand numbness affecting the palms and 1st three digits for the past two years. The Tribunal notes this time frame (2004) is after the MQP. He noted she developed bilateral hand numbness over 10 years previously, underwent right carpal tunnel release about 10 years earlier and the left side two year later. He indicated that although her symptoms improved initially, for the past two years, she had worsening bilateral hand numbness.

[156] Although the record suggests some worsening of the Appellant's CTS in or around 2004, (and therefore the absence of a continuously severe condition since the MQP) the Tribunal is not satisfied that the medical record supports a finding of ongoing substantially disabling symptoms and function. In his August 2006 report, Dr. Kong referred to clinical and electrophysiological evidence of mild bilateral CTS. In her May 2006 report, Dr. Lee indicated the Appellant had complained of some stiffness/heaviness in her right 2nd and 3rd digits at night for the past six months. She queried whether there was a worsening of CTS.

[157] The Tribunal further notes that the Appellant testified that she still drives a car and that in 2013, would drive between one-half hour and 45 minutes each way to and from school three days a week. She did not indicate difficulties with driving on account of her hands. She further testified that she stopped attending school due to the death of her son, not on account of problems with her hands.

[158] Based on the medical record and Appellant's testimony, the Tribunal is not satisfied that the Appellant's bilateral CTS was both severe and prolonged at the MQP.

vii) **Right lateral epicondylitis – right elbow pain since 1999**

[159] The Tribunal is not satisfied the Appellant's right lateral epicondylitis rendered her incapable regularly of pursuing any substantially gainful occupation on or before the MQP. There exists a dearth of medical reporting on this condition at or around the time of the MQP. Although the pre-MQP reports refer to this condition, no reports exist linking this to unemployability or significant restriction in function. In his August 2006 report, Dr. Kong reported that Tinel's sign was negative at both wrists and both elbows and that neither ulnar nerve was palpably enlarged.

viii) **Right ankle swelling**

[160] In his June 2010 report, Dr. Syed reported that the Appellant complained of right ankle pain on the lateral and medical aspect. He queried possible ligamentous injury of the right ankle.

[161] The Tribunal finds that the onset of this condition is many years after the MQP and that this condition is not relevant to the determination whether the Appellant was severely disabled on or before the MQP.

ix) **Urinary stress incontinence**

[162] The Tribunal is not satisfied that this condition resulted in a severe disability on or before the MQP. The medical reports described a problem with frequency and urgency of voiding. Although she received a pubovaginal sling in December 1997 prior to the MQP, according to the September 14, 2006 report of Dr. Almousa, the Appellant attended the clinic with complaints of increased and worsening symptoms the previous year, i.e., 2005, which resulted in a negative video urodynamic. In April 2010 long after the MQP, she underwent surgery to implant a neurostimulator for which she had a good response. Although she required surgeries in relation to the implant, the Tribunal is not satisfied that this condition was severe as defined in the CPP on or before the MQP.

x) **Hypothyroidism/High Blood Pressure/Chronic Anemia**

[163] The Tribunal has not been provided with any evidence that these conditions were severe as defined in the CPP on or before the MQP. Although she had variable blood pressure "over the last six months" according to Dr. Ogilvie's September 27, 2007 report, this was well after the MQP. Although the Appellant was diagnosed with some iron deficiency anemia, the medical reports do not indicate that this condition is not controllable with medication. In an August 15, 2011 report sent by Dr. Wang to Dr. Choi, Dr. Wang wrote: "..you had noted that she had a very mild anemia with normal iron". Similarly, the Appellant is prescribed synthroid for hyperthyroidism. The Tribunal is not persuaded that this condition was uncontrollable and/or resulted in secondary complications which rendered the Appellant severely disabled on or before the MQP.

xi) **Sleep Apnea**

[164] According to the July 8, 2013 report of Dr. Lee, the Appellant had a sleep study on April 19, 2013 which revealed not sleep apnea but sleep EEG changes including moderate Alpha EEG disorder which can cause unrefreshing sleep. She did not require a return follow up. This

condition was diagnosed approximately 13 years post- MQP. The Tribunal notes that the sleep study was requisitioned by Dr. Lee in or around December 2012 after the Appellant complained that her main concern "now" is difficulty sleeping "which is nonrestorative and she feels fatigued throughout the day". Although earlier medical reports described complaints of poor nonrestorative sleep and feeling fatigued through the day, for example, the November 25, 2008 report of Dr. Lee, such reports still postdate the MQP by many years.

[165] The Tribunal has also considered the Appellant's testimony that during 2013, she drove between one-half hour and 45 minutes each way to and from school where she attended between 8:00 am and 12:00 pm. She indicated she stopped attending school due to her son's death and not because she was unable to get up in the morning, concentrate behind the wheel or function in the classroom on account of fatigue.

[166] The Tribunal is not satisfied that the Appellant's sleep condition was severe as defined in the CPP on or before the MQP and continuously thereafter.

xii) **Atypical Chest pain**

[167] According to the April 10, 2007 report of Doctors Anand and Cavalcanti, the Appellant was noted to have had chest pains since November 2005. A stress echo performed in December 2005 was normal. A MIBI in June 2006 showed a small reversible LAD territory defect which was considered low risk. A September 2006 angiogram showed normal coronary arteries. There was increase LVDP showing diastolic dysfunction but normal left ventricular ejection fraction.

[168] The Tribunal notes the Appellant complained of additional episodes of atypical chest pain in or around 2009 (see October 21, 2010 report of Dr. Yu). On investigation, Dr. Yu advised the Appellant he doubted the symptoms were cardiac in nature and suggested a respirology referral.

[169] The Tribunal is not satisfied that the Appellant's atypical chest pain was severe as defined in the CPP on or before the MQP.

xiii) **Antalgic Gait/Numbness of Left heel**

[170] The Tribunal finds that the left ankle condition appears to be a relatively recent phenomenon. It was investigated in 2010. According to a September 2, 2010 report of Dr. Syed, an MRI did not show “anything much of note.” She was tender over the lateral aspect. Dr. Syed thought there might be some bursitis/inflammation along the lateral aspect and offered cortisone injection. The Tribunal is not satisfied that the above condition(s) was /were severe on or before the MQP within the meaning of the CPP.

Capacity Regularly to Perform Substantially Gainful Occupation

[171] Given the above findings, the Tribunal is not persuaded that the Appellant was incapable regularly of pursuing any substantially gainful occupation on or before the MQP.

[172] Even if the Appellant had some issues with her left shoulder, neck and residual post-surgical numbness in her hands following CTS surgery, which might have rendered repetitive work of a physical nature ill-advised or unrealistic, the Tribunal is not satisfied that the Appellant did not retain residual capacity to perform lighter work or pursue retraining.

[173] The Tribunal is satisfied, given her limited work experience and Grade 6 education that the Appellant would likely require retraining to secure lighter work. Given her relatively young age of 45 at the MQP and fluency in English, the Tribunal finds that retraining was a realistic option.

[174] According to the decision of *Inclima v. Canada (Attorney General)*, 2003 FCA 117 (CanLII) at paragraph [3]:

> Consequently, an applicant who seeks to bring himself within the definition of severe disability must not only show that he (or she) has a serious health problem but where, as here, there is evidence of work capacity, must also show that efforts at obtaining and maintaining employment have been unsuccessful by reason of that health condition”.

[175] The Tribunal notes the Appellant pursued retraining in 2013 involving reading, writing and using a computer, despite being diagnosed with many additional conditions which arose or deteriorated after the MQP. She testified she stopped attending school because her son died.

Given her demonstrated capacity to pursue retraining long after the MQP in the presence of additional or worsened medical conditions, the Tribunal is fortified in its view she had capacity to pursue retraining at or prior to the MQP.

[176] On the facts of this case, the Appellant has not satisfied the Tribunal as required by *Inclima* that she made an attempt on or before the MQP to pursue retraining or demonstrated that her efforts failed because of her health condition.

[177] The Tribunal is not satisfied that the Appellant's disability was severe and prolonged at the MQP.

CONCLUSION

[178] The appeal is dismissed.

Jeffrey Steinberg Member,
General Division - Income Security