Citation: ***P. S. v. Minister of Employment and Social Development,*** **2015 SSTGDIS 75**

Date: July 17, 2015

File number: GP-13-769

GENERAL DIVISION - Income Security Section

Between:

P. S.

Appellant

and

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

Respondent

Decision by: Raymond Raphael, Member, General Division - Income Security

Section Heard by Videoconference on July 16, 2015

REASONS AND DECISION

PERSONS IN ATTENDANCE

P. S.: Appellant Rajinder Johal:

Appellant's representative

INTRODUCTION

[1] The Appellant's application for a *Canada Pension Plan* (CPP) disability pension was date stamped by the Respondent on July 12, 2012. The Respondent denied the application initially and upon reconsideration. The Appellant appealed the reconsideration decision to the Tribunal on April 15, 2013.

[2] The hearing of this appeal was by Videoconference for the following reasons:

a) The form of hearing is most appropriate to allow for multiple participants;

b) The issues under appeal are complex;

c) There are gaps in the information in the file and/or a need for clarification; and

d) 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] 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).

[4] 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.

[5] 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

[6] The Tribunal finds that the MQP date is December 31, 2011.

[7] 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 date of the MQP.

BACKGROUND

[8] The Appellant was 39 years old on the December 31, 2011 MQP date; he is now 43 years old. He was born in Guyana and moved to Canada when he was four years old. He has a high school education as well as two years at George Brown College in an air conditioning technician course. He started working before completing college and worked for approximately five years as an air conditioning technician. He then worked installing electronics in vehicles. He started working as a long haul truck driver in 2002. In July 2009 he injured his back.

[9] The history of his injury is set out in a Workplace Safety Insurance Board (WSIB) Regional Evaluation Centre report dated September 11, 2009 as follows:

> Mr. S. is a 37-year-old, right-handed, truck driver, who sustained a work-related injury. Mr. S. reported that his pain began on April 20, 2009 as he was returning home from a long road trip. He felt pain across the posterior aspect of his legs and saw his family physician. Mr. S. was prescribed muscle relaxants and was referred for a MRI scan. Although his pain did not resolve, he continued to work, and was behind the wheel for approximately 8 to 14 hours per day. Mr. S. reports that one month later his pain became intermittent and was present predominantly on walking, while he tolerated sitting quite well.

> Then on July 8, 2009, while he was in Winnipeg, he felt excruciating low back and left leg pain. His co-driver called an ambulance that took him to the local Emergency Department. Mr. S. was given an injection of analgesic medication to no avail. His wife came from Toronto to Winnipeg and flew him home on July 20, 2009.

[10] In December 2011 the Appellant reinjured himself when he got out of bed after his leg started to cramp. After standing up, he fell to the floor unconscious with his entire body falling on his right knee. He tore the medial meniscus in his right knee. He underwent a right knee arthroscopy in June 2012.

[11] The Appellant has not returned to work since July 2009. He was initially on WSIB benefits but those benefits were terminated in 2011. In his oral evidence the Appellant stated that he hasn't appealed the WSIB decision, and that he is presently receiving no benefits.

APPLICATION MATERIALS

[12] In his CPP disability questionnaire, date stamped by the Respondent on July 12, 2012, the Appellant indicated that he has a high school education as well as one year of post-secondary school education. He noted that he last worked as a truck driver from July 19, 2007 until July 17, 2009, and that he stopped working because of a work injury. He claimed to be disabled as of July 17, 2009 and stated that the illnesses or impairments that prevented him from working included low back and left leg [pain], central stenosis and disc herniation, depression, and lumbar spine muscle decondition. He also noted that he cannot walk due to numbness in his left buttock and weakness in his left leg and left foot; that there is radiation to his right leg; and that he is unable to sit, lift, or carry.

[13] He explained his difficulties/functional limitations to be as follows: only able to sit or stand for 10 to 15 minutes; needs help and support when walking; not able to lift, carry, or reach; difficulty and pain when dressing; bowel and bladder movements take a very long time; not able to do household maintenance; poor memory and concentration; disturbed sleep and feels suffocation during the night; and very hard driving a car for long.

[14] A report dated April 25, 2012 from Dr. Bariana, the Appellant's family doctor, accompanied the CPP application. The report diagnoses chronic lower back pain, increased

lipids, hypothyroid, osteoarthritis, and secondary chronic pain. The report notes that the Appellant has seen a pain specialist, rheumatologists, and orthopedics for his conditions, and that he has a pending appointment for orthopedic intervention. The report also notes that there has been no change or improvement with treatment. The prognosis was fair.

ORAL EVIDENCE

[15] In his oral evidence at the hearing, the Appellant reviewed his education and employment history. He also described the circumstances of his back injury in July 2009 and his right knee injury in December 2011. He attended physiotherapy for approximately three years after his back injury; he initially went five days a week for 4-5 hour sessions, and after two years this was reduced to three days per week. He stated that the treatments involved learning to do everything all over again including how to walk, how to pick things up, and how to alleviate some of the pain by lying on the floor, and twisting one leg over his knee to realign his back.

[16] He stated that the pain is always there and that the only improvement has been with muscle movement; however, along with more movement came severe muscle and joint pain. He is still very limited and can't bend over to put on socks or tie up shoes. He still does exercises at home - but the only thing that helps to alleviate the pain is rest. In May 2010 Dr. Izukawa, an orthopaedic surgeon, told him that surgery wasn't necessary. He saw Dr. Mehdi, another orthopaedic surgeon, three weeks ago who strongly recommended back surgery. He has discussed this with his family doctor and will probably go ahead with the surgery.

[17] Dr. Bariana referred him to Dr. Pinto because of inflammation. Dr. Pinto told him that there was nothing he could do other than prescribe medications; he saw Dr. Pinto three or four times and Dr. Pinto put him on seven different medications. He also went to the Greenspon Pain Management Centre for two years; they performed back injections twice a week for two years. He found that his pain was worse after the injections, and when he told the doctor this he said that they would try different things. He stopped going for physiotherapy and to the pain management centre when the WSIB discontinued his coverage.

[18] He went for a sleep study in 2011 and they recommended a CPAP machine. He testified this that he didn't get the CPAP machine because he couldn't afford it. He first saw Dr. Dhaliwal, a psychiatrist, in September 2012. Dr. Bariana referred him to Dr. Dhaliwal because he was clinically depressed. He has seen Dr. Dhaliwal for about five or six sessions, and they mostly talked about pain management. He did not take the anti-depressants recommended by Dr. Dhaliwal because he is afraid that they may lead to suicide. He mentioned an incident in which one his daughter's school mates jumped off a balcony after she started on anti-depressants. He hasn't seen Dr. Dhaliwal since February 2012; he is not receiving any treatment for his depression – he is just dealing with this himself. He also stated that he wasn't taking the anti- depressants because he couldn't afford them. When asked whether he ever discussed this with Dr. Dhaliwal or approached the WSIB to cover the costs, he stated that he never thought about doing this. Similarly, when asked whether he approached the WSIB to cover the costs of the CPAP machine he again stated that he never thought about doing that.

[19] The Appellant stated that he now feels pain all over his body - in his joints, wrists, elbows, shoulders, hips, back, and knees. He also feels numbness and can only stand for two to three minutes. He is able to extend his right knee more after the arthroscopy, but both of his knees ache all of the time. He isn't able to concentrate because he always thinking about his pain.

[20] On a typical day, he gets up around 10 or 11. He tosses and turns from around 6:30; but he stays in bed to try and get enough rest so he will feel less pain for the rest of the day. He has difficulty when he goes to the bathroom, and sometimes gets cramps when wiping himself. He can't bend over, so his son helps him put on his socks. He lives in a two story house, and he finds it very difficult going up and down the stairs – he has to put his hands on the railings and slowly take one step at a time because his knees won't support themselves. Once he goes downstairs, he stays down all day. After breakfast, he relaxes on the couch in the living room; he watches television and his children's small dog keeps him company. If his back is really bad, he will lie on the floor and do exercises to try and put his back into place – his back pain is always there. He doesn't use a computer because it is too painful for his fingers to use the keyboards. He isn't able to do any housework and he doesn't go out.

[21] He attended a WSIB Labour Market Re-entry (LMR) program, and they found a job for him as a dispatcher with his former employer. He couldn't make it in to work on the first day because of his excruciating pain, and when he called the WSIB to tell them that he couldn't make it in to work, they terminated his benefits. He is no longer receiving WSIB benefits and didn't appeal their decision to terminate his benefits. He sees Dr. Bariana once a month, but other than seeing Dr. Mehdi three weeks ago, he is not seeing any specialists and isn't going for any treatments. His only medications are Synthroid for his thyroid condition and naproxen, an anti- inflammatory.

MEDICAL EVIDENCE

[22] The Tribunal has carefully reviewed all of the medical evidence in the hearing file. Set out below are those excerpts the Tribunal considers most pertinent.

[23] A MRI of the spine on July 5, 2009 revealed moderate sized central disc herniation at L5- S1 with disc material abutting both S1 nerve roots at the lateral recess.

[24] On July 20, 2009 Dr. Andruka, from the Trillium Health Centre, reported that the Appellant had been seen in the emergency department with moderate disc herniation and obvious sciatica. He noted that the Appellant needed better pain control with medications and that conservative therapy such as physiotherapy and epidural steroids should be attempted.

[25] A MRI of the right knee on July 27, 2009 revealed centrally located degenerative changes.

[26] On September 1, 2009 Dr. Bariana reported that on July 20, 2009 the Appellant presented with inability to walk, fainting, and left leg numbness. He noted that the Appellant went to the emergency department and after a neurosurgery consult was discharged to do physiotherapy and take pain medications (Percocet and Naproxen); that he had been referred to pain management for nerve blocks; and that the MRI shows L5-S1 disc herniation with S1 nerve impingement. The report concludes that if the Appellant does not improve he will require surgical intervention, and that he was to follow up after seeing the pain specialist.

[27] On September 11, 2009 a WSIB Regional Evaluation Centre assessment diagnosed left L5 and S1 radiculopathy secondary to disc herniation and an element of functional overly. The assessment indicates that the Appellant has partially recovered and that full recovery is anticipated within 3-4 months.

[28] On September 14, 2009 Dr. Leibovitz, pain management, reported that the Appellant has been suffering with lower back and leg pain since approximately April 2009. He diagnosed left- sided lumbar facet joint irritation and referred pain into the left lower extremity.

[29] A Functional Abilities Evaluation by Mike Postic, registered physiotherapist, on January 22, 2010 reported that the Appellant could perform work in the sedentary to medium work category at a job that would allow for frequent change in position, minimal lifting and the ability to work at his own pace.

[30] On May 14, 2010 Dr. Izukawa, orthopaedic surgeon, noted that the Appellant had slowly improved with conservative measures in the form of physiotherapy including back education and a low lumbar exercise program. He noted that the MRI confirms spondylosis at L5-S1 with a chronic-looking central disc herniation and associated osteophytes. Although there was a good imaging correlation with the clinical presentation, Dr. Izukawa did not recommend surgical intervention for the lumbar spine. He concluded that the Appellant needs to develop a dedicated and disciplined low lumbar exercise program for long-term use, and that he will carry on with pain management.

[31] On January 20, 2011 a final WSIB multidisciplinary report concluded as follows:

> Based on his performance in the program, Mr. S. is capable of beginning a labour market re-entry program with the goal of a light strength level occupation. It is recommended that he avoid bending and twisting of his lower back, as well as vibration. He will need to change positions intermittently and he continues to have limited standing and walking tolerances. The standing and walking tolerances are expected to gradually improve in the future with continue application of his home exercise program and pain management strategies. There were no significant psychological barriers to Mr. S.'s Labour Market Re- entry or return to gainful employment identified at the time of his program's completion.

[32] There are reports from Dr. Harrington, orthopaedic surgeon, from May 1, 2009 to June 20, 2012. The report dated May 1, 2009 indicates that although the Appellant was being seen with regards to his knees, he believed his back pain was a more significant problem. Examination was unremarkable, both knees were stable, and Dr. Harrington sent the Appellant for a MRI. On September 25, 2009 Dr. Harrington noted that the MRI shows some degenerative changes in the meniscus but no distinct meniscal tearing. The Appellant had peri-patellar pain in both knees, worse with going up and down stairs, no locking and no giving way. Dr. Harrington recommended physiotherapy.

[33] On March 9, 2012 Dr. Harrington saw the Appellant concerning his right knee. The Appellant stated that just before Christmas 2011 he suffered an incident where his left leg gave out, presumably because of issues involving his back, and that as a result he twisted his right knee. He noted immediate pain and discomfort involving the knee and that ever since then he has not been able to fully straighten it out. A MRI in January showed a medial meniscal tear. On examination the right knee was locked and Dr. Harrington opined that arthroscopic evaluation was warranted. On June 7, 2012 Dr. Harrington performed a right knee arthroscopy with multi- compartment debridement, partial medial meniscectomy and trimming of the lateral meniscus. The pre and post-operative diagnosis was internal right knee derangement. On June 20, 2012 Dr. Harrington reported that the Appellant continued to exhibit swelling and was walking with a limp. He recommended further physiotherapy and anti-inflammatory treatments. He discussed the possibility of future injections.

[34] On May 29, 2012 Dr. Joshi, rheumatologist, reported to Dr. Bariana with respect to a second opinion regarding the Appellant's low back pain. Dr. Joshi reported that the Appellant has significant low back pain and commented that only 1 of 16 tender spots was noted. He also commented that the Appellant may have an inflammatory component of spondylitis. He was to conduct further investigations and prescribed Celebrex. On June 28, 2012 Dr. Joshi reported that the Appellant had just had a right knee arthroscopy and that he returned with an antalgic gait. The Appellant had a bit of tenderness over the lumbosacral spine but it was not too bad. On September 24, 2012 Dr. Joshi reported that the Appellant has 15/18 tender spots.

[35] On September 26, 2012 Dr. Dhaliwal, psychiatrist, diagnosed major depressive disorder, pain, and pain causing depression. He noted that the Appellant has been suffering

from severe pain, insomnia, anxiety and depression which has now become full blown major depressive disorder. He assessed a Global Assessment of Functioning (GAF) of 40. On November 20, 2012 Dr. Dhaliwal reported that the Appellant had not started Cymbalta and Seroquel because his blood tests revealed increased AST and ALT. He recommended Effexor, Abilify, and Ativan as well as supportive therapy, cognitive based therapy, and mindfulness. On February 4, 2013 Dr. Dhaliwal reported that he Appellant did not take Effexor and Abilify because he was scared of the side effects. The Appellant wanted to try herbal medication, naturopathic, yoga, meditation and massage which Dr. Dhaliwal encouraged him to do. The Appellant was not willing to continue the usual anti-depressant therapy and treatment. The report concludes, "I will see him if again requested to see on consultation when he changes his mind. I will welcome to see him again."

[36] On November 24, 2014 Dr. Attar, rheumatologist, assessed the Appellant to rule out autoimmune disease. Dr. Attar opined that the Appellant has pain amplification that explains his generalized body aches and that he might benefit from a pain specialist.

[37] On May 8, 2015 Dr. Bariana noted that the Appellant's diagnoses include hyperlipidemia, chronic pain, hypothyroid, osteoarthritis, and depression. The prognosis was poor since the Appellant has already suffered in pain for five years. The Appellant's impairment was indicated to be at a high level if he does not follow up with a pain specialist and treatment plan. His return to work prospect was noted as unknown and Dr. Bariana indicated that the Appellant must follow up with his specialists for further return to work clarification.

SUBMISSIONS

[38] Mr. Johal submitted that the Appellant qualifies for a disability pension because:

a) He has multiple limitations in standing, sitting, walking, lifting, and twisting and suffers from multiple conditions including chronic back and knee pain, widespread chronic pain, sleep disturbance, and headaches;

b) He has pursued extensive treatment and seen numerous specialists, and has been unable to afford treatments such as a CPAP machine and anti-depressants;

c) Due to his multiple limitations and conditions he is incapable of pursuing gainful employment.

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

a) The Appellant's limitations do not prevent him from doing some type of work;

b) He successfully completed an Integrated Functional Restoration program with the WSIB and in January 2011 it was determined that based on his performance, he was capable of beginning a LMR program with the goal of a light strength level occupation including some activity restrictions. It was also determined that he had no significant psychological barriers.

c) There are no psychiatric reports subsequent to Dr. Dhaliwal's February 2013 report and it is reasonable to expect that with ongoing support and optimization of treatment, the Appellant will be capable of suitable work.

d) The Appellant is young, with a reasonable education, and there is no evidence that he has attempted alternative work suitable to his limitations.

ANALYSIS

[40] The Appellant must prove on a balance of probabilities that he had a severe and prolonged disability on or before December 31, 2011.

Severe

[41] The statutory requirements to support a disability claim are defined in subsection 42(2) of the CPP Act which essentially says that, to be disabled, one must have a disability that is "severe" and "prolonged". A disability is "severe" if a person is incapable regularly of pursuing any substantially gainful occupation. A person must not only be unable to do their usual job, but also unable to do any job they might reasonably be expected to do. A disability

is "prolonged" if it is likely to be long continued and of indefinite duration or likely to result in death.

Guiding Principles

[42] The following cases provided guidance and assistance to the Tribunal in determining the issues on this appeal.

[43] The burden of proof lies upon the Appellant to establish on the balance of probabilities that on or before December 31, 2011 he was disabled within the definition. The severity requirement must be assessed in a "real world" context: *Villani v Canada (Attorney General)*, 2001 FCA 248. The Tribunal must consider factors such as a person's age, education level, language proficiency, and past work and life experiences when determining the "employability" of the person with regards to his or her disability.

[44] However, this does not mean that everyone with a health problem who has some difficulty finding and keeping a job is entitled to a disability pension. Claimants still must be able to demonstrate that they suffer from a serious and prolonged disability that renders them incapable regularly of pursuing any substantially gainful occupation. Medical evidence will still be needed as will evidence of employment efforts and possibilities.

[45] The Appellant must not only show a serious health problem, but where there is evidence of work capacity, the Appellant must establish that he has made efforts at obtaining and maintaining employment that were unsuccessful by reason of his health: *Inclima v Canada (Attorney General)*, 2003 FCA 117. However, if there is no work capacity, there is no obligation to show efforts to pursue employment. Incapacity can be demonstrated in a number of different ways, for example, it can be established through evidence that the Appellant would be incapable of any employment-related activity: *C.D v MHRD* (September 18, 2012) CP27862 (PAB).

[46] The Appellant should demonstrate a good-faith preparedness to follow obviously appropriate medical advice and to take such retraining and educational programs as will

enable him to find alternative employment when it is obvious that one's prior employment is no longer appropriate: *Lombardo v MHRD*, (July 23, 2001), CP 12731(PAB).

[47] The term "prolonged disability" contains an element of reasonable self-discipline or personal responsibility. Following medical advice to exercise, diet, take medication, avoid alcohol or tobacco, or follow other conservative and reasonable treatments is expected of a person if such will ameliorate a potentially disabling condition. A person who continues to suffer from a condition that is reasonably avoidable or can reasonably be ameliorated, by taking available measures, cannot be said to be suffering from a disability that is of prolonged or indefinite duration: *Smith v MHRD* (May 29,1998) CP 5068 (PAB).

Application of Guiding Principles

[48] The Tribunal has determined that the Appellant has failed to establish on the balance of probabilities a severe disability in accordance with the CPP criteria.

[49] The evidence establishes that the Appellant is not able to return to his previous employment as a long haul truck driver. The evidence also established that the Appellant suffers from longstanding chronic pain and depression. The primary issues that the Tribunal must determine are whether the Appellant has the capacity to pursue alternative gainful employment and whether he has been compliant with respect to reasonable treatment recommendations. In considering these issues the Tribunal must keep in mind that that the Appellant has the burden of and that it is important to focus on the December 31, 2011 MQP date.

Capacity to Pursue Alternative Employment

[50] The Appellant was only 39 years old on the December 31, 2011 MQP date; he has a good education and his work history confirms that he has significant transferable skills. The Functional Abilities Evaluation in January 2010 indicates that he has the capacity to perform work in the medium work category. The January 2011 WSIB multidisciplinary report concludes that he is capable of beginning a LMR program with a goal of a light strength level occupation. Dr. Bariana's April 2012 report (four months after the MQP) indicates that the

Appellant's prognosis was fair and his May 2015 report indicates that the Appellant's return to work prospect is unknown and that he must follow up with his specialists for further return to work clarification. These reports support that the Appellant had the capacity to pursue alternative employment as of the MQP.

[51] In his oral evidence, the Appellant acknowledged that he has not made any return to work attempts since July 2009. He participated to some degree in the LMR program and arrangements were made for modified work as a dispatcher with his former employer. The Appellant testified that when he could not show up for work on the first day because he was experiencing excruciating pain, the WSIB terminated his benefits. Inexplicably he did not appeal that decision.

[52] Although extensive documentation has been included in the hearing file, there are no LMR reports or other documentation relating to the WSIB decision to terminate the Appellant's benefits. This documentation is of significant relevance to this appeal and is readily available to the Appellant. The Appellant has the burden of proof and his failure to include this important documentation in the hearing file was a factor considered by the Tribunal in its determination that the appeal should be dismissed.

[53] The Tribunal finds that as of the MQP date the Appellant had the capacity to pursue alternative less physically demanding employment and that he failed to make reasonable efforts to do so. The Appellant has failed to meet his obligations as set out in *Inclima* supra.

Compliance with reasonable treatment recommendations

[54] The Appellant has pursued extensive treatment modalities for his physical conditions and has seen many specialists in this regard. However, an important component of his claim for disability is his depression. Although he has seen Dr. Dhaliwal, a psychiatrist, on four or five occasions, he has failed to comply with Dr. Dhaliwal's reasonable recommendations for anti- depressant medications. In addition, there is no evidence of any significant attendances for supportive psychological therapy. Anecdotal evidence concerning the tragic suicide of one of his daughter's friends is not a reasonable basis for failing to at least attempt these

recommendations. The Appellant acknowledged in his oral evidence that he is not pursuing any treatment for his depression.

[55] The Tribunal also noted that Dr. Bariana's May 2015 report indicates that the Appellant's impairment was at a high level if he does not follow up with a pain specialist and treatment plan. This suggests that the Appellant has failed to follow up with recommended pain specialist treatment and that his doing so may be helpful. The Tribunal also noted that the Appellant made no efforts to obtain a CPAP machine which was recommended after a sleep study in 2011. The Appellant stated that he could not afford this but did not explore whether government funds were available and did not approach the WSIB for funding.

[56] The Tribunal finds that the Appellant has been non-compliant with reasonable medical treatment recommendations. [See *Lombardo* and *Smith*, supra].

Prolonged

[57] Since the Tribunal found that the disability was not severe, it is not necessary to make a finding on the prolonged criterion.

CONCLUSION

[58] The appeal is dismissed.

Raymond Raphael
Member, General Division - Income Security