Citation: ***V. M. v. Minister of Employment and Social Development,*** **2015 SSTGDIS 84**

Date: August 10, 2015

File number: GT-124643

GENERAL DIVISION - Income Security Section

Between:

V. 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 July 13, 2015

REASONS AND DECISION

PERSONS IN ATTENDANCE

V. M., the Appellant

Steven Sacco, the Appellant's legal representative

J. M., the Appellant's son (observer)

INTRODUCTION

[1] The Appellant's application for a *Canada Pension Plan* (CPP) disability pension was date stamped by the Respondent on September 29, 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 Videoconference for the following reasons:

a) Videoconferencing is available in the area where the Appellant lives;

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

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

THE LAW

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

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

a) be under 65 years of age;

b) not be in receipt of the CPP retirement pension;

c) be disabled; and

d) have made valid contributions to the CPP for not less than the minimum qualifying period (MQP).

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

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

ISSUE

[7] There was no issue regarding the MQP because the parties agree and the Tribunal finds that the MQP date is December 31, 2013.

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

EVIDENCE

Documentary Evidence

[9] In the CPP Questionnaire dated August 20, 2011, the Appellant reported that she completed Grade 12 and a Canadian Securities course in 1999. She obtained her Mutual Funds license. She worked between September 1, 1978 and October 28, 2009 as a CIBC manager. She stopped working due to a history of Transient Ischemic Accidents (TIAs). In July 2009, she changed job her duties from that of branch manager to client service manager to try to reduce her stress levels. However, she was not successful as she suffered another TIA in October 2009. She is prone to TIAs and had her first episode in May 2007, her second in October 2008 and a third

in October 2009. She suffered a recurrence in January 2010 due to high stress. Migraine auras cause her TIAs. She suffered another episode on June 17, 2011 and was admitted to Etobicoke General Hospital. She has a high stress job. Her medications taken to prevent a full-blown stroke have severely affected her memory, speech and clarity of thought. This causes her to experience an overwhelming amount of stress, which renders her unable to make decisions and function in her job. She also described back problems, depression, difficulties with slurred speech and loss of words and problems with memory and concentration. She has to write things down and has trouble with short and long-term memory. She is unable to stay focused, feels overwhelmed with information and is unable to concentrate. She also has trouble sleeping. She is okay with driving but many times feels like she is not focused.

[10] On August 3, 2011, Dr. Gideon completed the CPP Medical Report. She stated she knew the Appellant since 1998. She diagnosed: 1) history of TIAs starting out as migraines with speech disturbance and confusion; 2) hypertension; 3) hypercholesterolemia; 4) moderate obstructive sleep apnea and snoring; 5) psoriasis significantly increased due to increased stress; and 6) depression and anxiety secondary to disability. Dr. Gideon described increased psoriasis involving the arms, abdomen, back and legs and stuttering and slower speech. She wrote: "definitely not as sharp mentally as she used to be" and "easily fatigued and increased weight gain secondary to depression and lack of mobility." She stated the prognosis was guarded and that there was no definite diagnosis/treatment.

May 2007 Episode

[11] On May 30, 2007, Dr. Dhanani saw the Appellant in neurologic consultation regarding acute onset of speech disturbance. According to Dr. Dhanani, the Appellant reported feeling suddenly confused at her desk at work. She had difficulty writing, focusing and was unable to speak. She attended the Emergency Room with a stuttering type of speech. Dr. Dhanani noted a history of transient speech disturbance two years earlier. He stated he could not completely rule out an ischemic event and suggested an MRI scan and work-up for stroke.

[12] A May 30, 2007 CT of the head was normal.

[13] A May 31, 2007 MC routine doppler revealed some flow irregularity seen in the distal right intracranial vertebral artery possibly due to vessel hypoplasia/stenosis. Its clinical significant was unclear. No significant carotid stenosis was noted. A June 1, 2007 MRI of the head was negative.

[14] On September 14, 2007, Dr. Dhanani reported on the Appellant's admittance to Trillium Health Centre (THC) between May 30 and June 1, 2007 with transient speech disturbance of unclear etiology. He stated that since discharge, she had generally been doing well. An MRI, MRA, carotid and vertebral Doppler, 2D echocardiogram and ECG were all normal. The Appellant complained of some fatigue and hoped to return to work in the near future. Dr. Dhanani stated her stuttering type of speech would be very unusual as a manifestation of migraine. He stated she could not identify other stressors at work or home which could be causing her symptomatology. He indicated she was doing well and stated the exact cause of her stuttering type of speech was not completely clear to him. He doubted ischemia was the cause, stated it was reasonable for the Appellant to return to work and expressed surprise she had not yet done so. He indicated the personal and social causes for her overall symptoms needed to be explored.

October 2008 Episode

[15] On October 23, 2008, Dr. Temple saw the Appellant in the Emergency Room regarding a possible stroke. He stated she was previously admitted to THC on May 30, 2007 and was assessed by Dr. Dhanani. At that time, she had complained of slight blurring of vision and stuttering speech. She had a normal CT of the head; a June 2007 MRI of the brain was also normal. At the time Dr. Temple saw the Appellant, she was complaining of visual aura typical of her usual migraines followed by difficulty with speech. The speech deficit persisted and she had a stuttering and nonfluent speech. Dr. Temple suspected it most likely represented a migraine aura. He noted she had no significant motor deficits and good comprehension. Although her speech was nonfluent and stuttering, it was still functional. He arranged for a repeat MRI of the brain.

[16] An October 24, 2008 MC Routine Doppler was unremarkable. An October 25, 2008 MRI of the head was negative.

[17] On October 27, 2008, Dr. Dhanani reported on the Appellant's October 23, 2008 admission to THC with complaints of speech disturbance. She had experienced visual aura followed by a mild headache which developed into a speech disturbance consisting of a stuttering type of speech. She also had difficulty writing. She had an MRI scan of the brain which did not show any significant sign of stroke. There were some non-specific white matter changes likely due to migraine. Dr. Dhanani noted the Appellant was previously admitted with similar symptoms. She had a complete work up to rule out risk of stroke. Her investigations were unremarkable including repeat carotid and vertebral Doppler. The Appellant indicated her headaches were occurring at least two times per month. Dr. Dhanani discharged the Appellant on October 27, 2008 with a diagnosis of 1. Complicated migraine with visual aura and speech disturbance, 2. Hypertension; 3. Hyperlipidemia and 4. Psoriasis.

[18] On November 4, 2008 Dr. Rodriguez, respirology and sleep medicine, reported on the Appellant's sleep study. He indicated she had moderate obstructive sleep apnea with snoring, increased arousals and sleep fragmentation. On November 6, 2008, Dr. Rodriguez reported there was strong indication for use of nasal CPAP.

[19] On December 17, 2008, Dr. Temple saw the Appellant at THC. He noted i) a previous admission in May 2007 with an event in which she was confused, had difficulty focusing and speaking; and ii) re-admittance on October 23, 2008 with an episode of visual symptoms associated with a feeling of confusion, difficulty speaking and writing. A CT scan of the head was normal and an MRI of the brain failed to show evidence of an infarct or other abnormality. It was thought her episode represented a complicated migraine. She was discharged from hospital and had no further neurological episodes. According to Dr. Temple, the Appellant's speech was normal and the remainder of her detailed neurological examination was intact. Dr. Temple formed the impression the Appellant had a longstanding history of episodes most consistent with complicated migraines with visual aura and speech disturbance. He recommended she remain on Nadolol daily for migraine prophylaxis.

October 2009/January 2010

[20] On October 29, 2009, Dr. Cuthbert, internal medicine, reported he saw the Appellant following a TIA. He noted she discontinued her medications six weeks earlier without informing

her neurologist. He reported that her CT head scan was negative. No arrhythmias were detected on cardiac monitoring. He advised her to go back on treatment.

[21] On June 24, 2010, Dr. Boulios, physiatrist, assessed the Appellant. He performed a mini mental status examination in which the Appellant scored 29/30. He indicated her speech was fluent and comprehension intact. She had no indication of anomia. However she became a little "flustered" performing serial 7s. Her speech became almost stuttering but was "not quite there". He stated he was not quite sure what to make of her symptoms and referred her to see a language pathologist.

[22] On July 5, 2010, Dr. Dhanani assessed the Appellant. He noted she was off work since October 2009. He recounted the fact she was seen at THC in May 2007 when she presented with unusual stuttering speech. The possibility of transient ischemic attack (TIA) was raised. No significant abnormalities were identified on testing. Nonspecific white matter changes on her MRI scan were felt to be related to underling migraine but not suggestive of stroke. She was seen again at THC in October 2008 with speech disturbance and some visual symptoms. Diagnosis of migraine was felt to be most likely. The Appellant reported she had further symptoms in October 2009 when she again presented with stuttering speech. CT of the brain was unremarkable. She had some further symptoms in January 2010. Her main concern was that her speech and thoughts were somewhat slowed. She was therefore unable to return to work. She was further experiencing an odd aura involving blurring of vision in her left eye. Dr. Dhanani suspected that a considerable number of symptoms were related to underlying stress and possible depression. He stated her current symptoms were not suggestive of stoke. He indicated while she may have had migraine, she was not having frequent headaches at the time. He stated he did not feel that migraine was the cause of her current symptomatology involving slowed speech or thoughts. He further stated her neurologic examination was normal, noting her previous imaging and extensive testing had not revealed any other significant abnormalities. He indicated she may benefit from being referred to a psychiatrist. He also recommended adjustment to her medications if they were causing some side effects.

[23] On October 5, 2010, Mr. Thacker, Speech Language Pathologist, assessed the Appellant regarding her speech disturbance. He indicated that many of the dysfluencies in her speech were

characteristic of those heard in the speech of individuals with neurogenic stuttering. She demonstrated significant dysfluency during the speech assessment. She also presented with numerous findings known to sometimes co-occur in persons with neurogenic stuttering: some language-related impairment, including impaired discourse comprehension, impaired reading, anomia and difficulty imitating longer hand-tapped rhythm sequences. Mr. Thacker made the following recommendations: further assessment of the Appellant's dysfluency by a speech language pathologist that could be arranged by the family doctor; that the family doctor arrange for a pharmacist to rule out any relationship between her medications and drugs known to be associated with stuttering, impaired verbal or reading recall, impaired listening and reading comprehension or word finding and a course of communication rehabilitation.

[24] On April 26, 2011, Dr. Chilly, registered psychologist, assessed the Appellant. She indicated, based on the Appellant's presentation and reported history that the Appellant was suffering from an Adjustment Disorder with Mixed Anxiety and Depressed Mood. Based on her self-report, the Appellant was struggling to cope with multiple stressors. There was frustration and some anxiety around her limitations, expressive speech and cognitive dysfunction, which created a negative feedback loop exacerbating her functional difficulties. She appeared to be experiencing greater distress, fear and anticipatory anxiety around the possibility of another TIA or stroke. Dr. Chilly sensed that the Appellant's prominent clinical issue was her profound sense of loss around her work. Her depressive symptoms were reactive to her loss of routine, identity and purpose which her work provided. Dr. Chilly wrote: (The Appellant) appears to be grieving this loss, to the extent that she previously 'bargained' for a return by discontinuing her medically necessary medication". Dr. Chilly indicated she would continue to provide individual psychotherapy sessions.

[25] On July 7, 2011, Dr. Rodriguez saw the Appellant in follow up. He indicated she never had a nasal CPAP titration study but preferred to wait. He stated she had previous episodes of TIA, one of which left her with dysphasia for several months. He queried whether it was an actual established stroke. He stated she suffers from migraine, sleeps four to five hours and feels unfreshed with lack of energy. He indicated he thought there was a component of significant depression and noted on examination she appeared a bit depressed. He stated there was strong indication for treatment with nasal CPAP.

[26] On August 27, 2011, Dr. Domitrovic, C. Psych reported on her neuropsychological examination of the Appellant. She described the Appellant as a 51 year old right hand dominant married female high school graduate and Branch Manager at the CIBC, who had been off work since October 2009 after experiencing a series of TIAs. She was seeking LTD benefits based partly on the allegation that cognitive difficulties and speech problems prevented her from returning to work. The Appellant reported she suffered her first TIA in May 2007. She did not return to work for five months and returned to full time duties in October 2007. Apart from an increase in migraine frequency and some element of speech difficulty, she reported she was back to her pre-TIA status. She suffered her second TIA in October 2008 at work. She indicated she was left with a persistent expressive speech difficulty but "forced" herself to return to work six weeks later. She found the job more stressful not only because of expressive speech difficulty but also because of difficulties with concentration and memory and a continuous state of "mental fogginess". She carried on as best she could until suffering a third TIA in October 2009, which resulted in a worsening of her cognitive issues. She did not return to work. She reportedly continued to experience episodic neurologic events suspicious for TIAs, e.g., in January 2010 she was temporarily unable to speak. She reported that her current symptoms included: 1. Difficulty speaking; 2. Mental fogginess; 3. Reduced memory; 4. A dull but chronic headache; 5. Constant fatigue; 6. Persistent sadness, depression and problems with mood accompanied by an increased tendency to cry; 7. Sporadic dizziness that can last several days; and 8. Non-restorative sleep. The Appellant reported she was independent in all basic and most instrumental activities of daily living. She still had her driver's license and would occasionally drive short distances. Dr. Domitrovic reported that the Appellant's thought processes were logical, coherent and goal oriented. Her mood was mildly dysphoric and she was emotionally labile and cried easily.

[27] Dr. Domitrovic diagnosed Stuttering (Acquired-Neurogenic) and Depressive Disorder Not Otherwise Specified. She stated that testing revealed "prominent" challenges in expressive speech in the absence of aphasia with characteristics most consistent with acquired stuttering. The Appellant's deficit in speech production was consistent with neurogenic stuttering. She also demonstrated an isolated impairment in left-handed fine motor dexterity coupled with very slightly reduced performances in judgment of angular distance. Otherwise, her neurocognitive profile was not suggestive of striking impairment. From an affective perspective, her presentation and self-reported symptoms were consistent with a depressive disorder. Dr.

Domitrovic stated the Appellant's phenomenology of cognitive dysfunction was likely multi-determined, noting that individuals who are depressed often have subjective complaints of disturbances in concentration, memory and speed of thought. She stated it was very likely that the Appellant's speech challenges secondarily affect cognitive efficiency. Although Dr. Domitrovic noted that medication monographs indicate that headache can be a side-effect of Aggrenox, and headache and lightheadedness a side-effect of Lipitor and Amlodipine, she also stated the most recent review of drug-induced stuttering she could locate did not implicate the Appellant's current medications. She also stated that pharmacological treatment of the Appellant's sleep disturbance and emotional lability may increase her sense of well-being and diminish her phenomenology of cognitive inefficiency to some extent.

[28] According to Dr. Domitrovic, strictly speaking, neither the Appellant's affective status nor her general neurocognitive profile would necessarily contraindicate a return to her previous employer or any gainful employment for which she is reasonably suited by education, training and/or experience. However, she also stated: "Rather, it is her striking speech dysfluency and challenge with oral communication, coupled with various symptoms that can secondarily affect cognitive inefficiency (e.g., a constant headache and dizziness, fatigue) that will create marked challenges in her resuming gainful employment of any kind". Dr. Domitrovic wrote: "It will be very difficult for her to pursue any such activity without treatment of her current speech difficulties. In that regard, I again defer to Mr. Thacker's recommendation that she undergo further assessment and a course of communication rehabilitation with a speech –language pathologist well-versed in the treatment of stuttering disorders."

[29] During a November 13, 2012 telephone conversation with the Respondent, the Appellant reported that she continued to have migraines "weekly – sometimes". They can last from hours to a day. She continued with the same medications and was taking Cipralex 10 mg daily since May 2012 or before. She did not cry as much now. She reported that "auras" affected her speech and that her medications made her feel slow. She was using CPAP for sleep apnea but found it stressful as it did not fit properly. She was trying nasal prongs. She indicated she had not received treatment from a speech language pathologist but had continued with psychological support on and off. According to the Respondent, the Appellant stuttered during the conversation but was able to answer questions and carry on a conversation.

[30] On September 11, 2013, Dr. Chilly, registered psychologist, reported that she first met with the Appellant on April 11, 2011. Based on the Appellant's presentation and reported history, Dr. Chilly suspected she was suffering from Adjustment Disorder with Mixed Anxiety and Depressed Mood. She described her findings in her earlier report and indicated she continued to meet with the Appellant for individual psychotherapy sessions biweekly. They "paused" their work in December 2011 at which time the Appellant reported and presented with some mood amelioration, attenuation of anxiousness and worry, and improved self-competence and coping with her medical issues as well as transition out of the workforce. At that time, Dr. Chilly advised the Appellant her file would remain open. According to Dr. Chilly, the Appellant contacted her again in July 2013 expressing interest in resuming their work. They met in August 2013 at which time the Appellant expressed devastation at the sudden death of her younger brother. Her grief manifested in thoughts dominated by loss and tearful spells. She conceded to experiencing appetite, weight and sleep changes and other depressive signs since the loss. According to Dr. Chilly, diagnostically, the Appellant's bereavement was now of the nature, severity and duration to suggest a depressive episode in the context of Major Depressive Disorder. Her serial loss, including her health, work and death of her brother, contributed to her depression. Dr. Chilly wrote: "Her symptoms have compromised her mood, cognitive functioning, interpersonal relating, and adaptability to stressors. Equally concerning, (the Appellant's) efforts at self-care have diminished; weight gain, reduced exercise and disrupted sleep are significant risk factors for an exacerbation of (the Appellant's) medical issues." Dr. Chilly stated she would provide support and treatment. Psychotherapy would focus on helping the Appellant to begin a healthy grieving process around loss. Specific treatment goals were also established concerning a return to independent self-care, renewing ongoing relationships and re-engaging with life.

Oral Testimony

[31] She is age 55.

[32] She was born in Italy.

[33] She came to Canada in 1967.

[34] She completed Grade 12 in 1978.

[35] CIBC hired her in 1978. She found her "passion" dealing with people and has been with CIBC her whole life.

[36] She worked her way up from teller to loans officer, officer in charge starting in1986, and finally branch manager starting in 1990.

[37] She received on the job training and was also a licensed mutual fund representative.

[38] As branch manager, she was responsible for the overall success of the branch. It was a high stress position.

[39] In 2007, she had her first episode. She was having a stressful week. Toward the end of day, she suddenly felt strange, could not write her name or speak and felt a sense of confusion. She went off work under her doctor's care. She "pressed" herself to return to work after 5 months. She felt she needed to return to manage the branch. She was still struggling. She asked her employer to provide her with supports, which they did.

[40] In 2008 she had another episode similar to the first. She was off work two months. She returned to work against her doctor's orders. She believed if she stayed off work longer, it would be more difficult to return to the job in terms of workload and issues she would have to address on her return.

[41] She had another episode in 2009. She was on many different medications which affected her train of thought. She felt she was living in a "fog". She could not sleep properly and was also depressed. She realized she could not function and suggested to her employer that she try another position which was less stressful. She transferred to a client service representative (CSR) role, however she still had trouble. She stopped taking the medication which was keeping her in a "fog". This caused herself to experience another episode.

[42] She repeatedly asked Dr. Gideon when she could return to work. Dr. Gideon told her she was not ready to return to work and to stop asking when she could do so.

[43] She has not worked since October 2009.

[44] CIBC has not contacted her to offer another job.

[45] She no longer has TIAs. They are controlled by medication although she had a few episodes after 2009. She takes her medication and feels okay in terms of episodes but still has headaches and migraine auras. Sometimes her speech is affected. She struggles to sleep and get up in the morning. She also struggles with CPAP. She uses nasal prompts. She feels she sleeps less with CPAP than without it. She experiences less stress now than when she was working but finds she struggles "within" herself. She misses her job and feels she has no purpose anymore. She feels her whole life has been disrupted. She still feels depressed and anxious.

[46] She was recently put on Methotrexate for psoriatic arthritis which affects her joints and knees. The condition was diagnosed in 2013. When she takes her medication, she has headaches for about two days and gets bloated for three days. She has gained weight. She has also struggled with psoriasis her whole life. Stress makes it worse.

[47] She was also recently diagnosed with hypothyroidism. She recently started a new prescription.

[48] She has stopped living her life.

[49] She feels worse today than before and that she has no purpose.

[50] During a typical day, she struggles to get out of bed. She does not socialize the way she used to. She tries to get out of events and feels she has affected her family and marriage. Her son will drive her around if he is at home. Her spouse works out of town a lot. She can drive to the plaza close to home. She cannot handle long drives due to her lack of focus. She struggles to descale the coffee machine but has difficulty following four simple instructions. Her medication has affected her mind.

[51] When she went off her medication, she had to prove to herself "it was not her". Now she knows she has to be on her medication.

[52] She can prepare her own meals and do some laundry. There are days she just wants to lie in bed and not see or hear anything. Some days she forces herself to go out and try to do something.

[53] She had a knee problem in 2011 due to her psoriatic arthritis. This condition has affected her ankles, knees and wrists. She has been on Methotrexate for almost two years. She sees Dr. Gladman at Toronto Western and will discuss a possible change of medication when she sees her in August 2015.

[54] She does not believe there was any job she could perform at CIBC in 2013 due to the constant fog in her mind. She cannot stay focused. She needs to be clear when dealing with finances, numbers and clients. If her doctor told he she could return to work, she believes CIBC would have a job for her.

[55] She saw Dr. Chilly again in 2013. Her treatment was paid for by CIBC up to $500. The rest is paid out of pocket.

[56] She has come to terms with her depression and anxiety. She takes medication. She has taken Ciprolex. She has tried to figure out why she feels the way she does and thinks it is due to the loss of her job and her brother.

[57] In response to the Tribunal's questions, the Appellant clarified she moved from the position of branch manager to that of CSR in July 2009. She went off her medication shortly after she took on the CSR job as she could not stay focused. After being off the medication for about 5-6 weeks, she felt herself again. Shortly afterward, she had another episode.

[58] She currently uses nasal prongs for CPAP. She had tried different masks and finds the nasal prong is the most intrusive. There are days she tries to use the prongs and other days she rips them out in the middle of the night. She has not gone back to see Dr. Rodriguez during the past year. Her daughter suggested she see him to find out if there is anything new or less intrusive he can offer. Her plan is to check it out at some point.

[59] After she saw Dr. Thacker in October 2010, she did not follow up with another speech pathologist. Her speech has gotten better and it is a lot better today. It gets compounded when she has an episode. Her speech is not where it was before the episodes. She still struggles to get some words out. She does not know why. Her medications are also a factor in how her speech is affected. The family doctor never referred her to a specific speech pathologist. She would have read the speech pathologist report at the time it was issued.

[60] In August 2013, she resumed seeing Dr. Chilly. She saw her every other week until she used up her $500.00 employer benefits coverage. She saw Dr. Chilly for approximately four months. She speaks with her on and off when she feels she needs someone to listen to her. She last touched based with Dr. Chilly in or around November 2014. Her employee benefits coverage is $500.00 annually. She does not know why she did not resume treatment with Dr. Chilly in 2014 and 2015.

[61] She can drive a short distance for approximately 10 minutes. Her focus is not there. She is afraid to drive a longer distance. She may drive two times and sometimes up to three times a week.

SUBMISSIONS

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

a) She has Grade 12 and worked as a bank manager. She stopped working on October 28, 2009 due to a history of TIAs. Her diagnoses include TIA from migraine, speech disturbance and confusion, hypertension, hypercholesterolemia, moderate obstructive sleep apnea, psoriasis and depression and anxiety. She is easily fatigued and has increased weight gain secondary to lack of mobility.

b) Her medication helps relieve depression. However, sometimes she has to limit the medication due to unpleasant side-effects. She has noticed some improvement in mood but still experiences lengthy episodes of depression. She has received psychotherapy.

c) Her disability is long-term and of indefinite duration. She has been off work since October 2009. She has prominent challenges in expressive speech which have been getting worse over time. Her speech problems affect her ability to be competitive in the labor market. Her depression has been slow to respond to treatment. It has become progressively worse over time. She experiences poor concentration, insomnia, lack of motivation and irritability.

d) Her speech problems and mental impairment are severe enough to prevent her from pursuing any kind of work. She cannot deal with the public. She is sensitive to every reaction and has become dependent due to her speech problems. She has discovered her depression makes it difficult to sustain even sedentary activities. It has become a major barrier to securing any kind of employment. When she has episodes of severe depression, she lacks motivation, cannot concentrate or be around people.

e) She cannot retrain. Her family doctor's poor prognosis confirms she is disabled from engaging in any occupation or retraining.

f) Based on her testimony and the medical record, she has a severe and prolonged disability which started before the MQP. She has multiple medical conditions which prevent her regularly from performing any substantial or gainful employment. She got worse doing a lighter position at work. She has been advised by her treating physicians to remain off work. It is not realistic for her to return to her former stressful work environment. The family doctor's CPP Medical Report sets out numerous medical conditions (six) which are significant. When they are considered in combination, she cannot function. The TIAs are controlled with medication. The sleep apnea is controlled to some degree. She has significant functional limitations, stuttering of speech, is not sharp mentally (side effect of medications), is easily fatigued, suffers lack of mobility due to problems with her joints and has gained weight. The prognosis is guarded. She has had depression and anxiety. She still sees a psychologist (see Dr. Chilly's 2013 report). The treatment goal back then was to get her back to self-care and re-engagement with life. There was no mention about reintegration with the workforce. There has been no workplace offer extended to her and she cannot be rehabilitated to return to work.

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

a) She completed Grade 12. She worked as a bank manager until she stopped working in October 2009 due to a history of TIAs. Following her second hospitalization, she was diagnosed with migraines, which are treated with medication. According to the neurologist, her headaches are infrequent and not suspected to be the cause of her symptoms. Her treating neurologist suspected that a considerable number of her symptoms were related to underlying stress and possible depression. He did not feel her symptoms were suggestive of stroke and reported that her overall neurological exam was normal. He did not preclude her from working.

b) The Appellant reports issues with her speech and slowed thinking. Referral and treatment by a speech language pathologist has been recommended. She has not participated in this mode of treatment.

c) Psychological issues in terms of depression and anxiety were suspected as a possible cause of some of her symptoms. It is noted she receives psychological support on and off and she has been prescribed a low-dose antidepressant. There is no indication she has required any acute psychiatric care or follow-up.

d) While acknowledging she may not be able to return to her previous job given the stress levels associated with her position, there has been no information or mental status exam findings submitted that indicate she would be precluded from all types of suitable work.

e) Dr. Chilly, psychologist, reported she first saw the Appellant in April 2011. She suspected Adjustment Disorder with mixed anxiety and depressed mood. She provided psychotherapy sessions biweekly which ended in October 2011. She relayed that the Appellant learned to cope with her medical issues and transition out of the workforce. She stated the Appellant contacted her in August 2013. Dr. Chilly diagnosed Major Depressive Disorder. She indicated psychotherapy would focus on helping her begin a healthy grieving process. No further reports were provided even though Dr. Chilly stated the Appellant was to undergo further psychotherapy. She responded to treatment in the past. She stopped treatment in October 2011 and did

not return again until August 2013. It is reasonable to expect she will respond favorably as she did previously.

ANALYSIS

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

Severe

[65] The Tribunal is not satisfied that the Appellant's disability was severe on or before the MQP.

[66] Although the Appellant testified that sometimes her speech is affected and it is not where it was before the episodes, the Tribunal notes that the Appellant never followed up with Mr. Thacker's October 2010 Speech Language Pathology Assessment recommendation, endorsed by Dr. Domitrovic in August 2011, that she be referred for further assessment of her dysfluency to Dr. Kroll, a speech language pathologist, through the family doctor.

[67] Although the Appellant testified her family physician never referred her to a specific speech pathologist, the Appellant testified she would have read the speech pathologist report at the time it was issued. The Tribunal is not satisfied the Appellant reasonably took steps to mitigate her circumstances and pursue the treatment recommended by Mr. Thacker since she did not pursue the matter with her family doctor.

[68] In any event, the Appellant testified her TIAs are controlled with medication and that her speech has much improved. The Tribunal notes she testified without stuttering throughout the hearing and was able to adequately express herself.

[69] Therefore, the Tribunal is not satisfied the Appellant's speech dysfluency constituted a severe and prolonged disability at the time of the MQP.

[70] Although the Appellant has been diagnosed with Adjustment Disorder with Mixed Anxiety and Depressed Mood and more recently with Major Depressive Disorder (see Dr. Chilly's September 2013 report), the Tribunal is not satisfied the Appellant has reasonably pursued the treatment recommended and offered by Dr. Chilly. She stopped treatment in late 2011 at which time she reported and presented with some mood amelioration, attenuation of anxiousness and worry, improved self-competence and coping with her medical issues and transition out of the workforce. She did not resume treatment until August 2013 following the loss of her younger brother. Although she testified she pursued treatment with Dr. Chilly for approximately four months and speaks with her over the phone from time to time, she was unable to explain why she did not resume ongoing treatment with Dr. Chilly in 2014 and 2015. This is especially the case since she had employee benefits coverage of $500.00 annually to pay for therapy.

[71] The Appellant's legal representative notes that the goal of therapy described by Dr. Chilly in her September 2013 report was not to return to work but to focus on starting a healthy grieving process around loss and establishing treatment goals of returning to independent self-care, renewing ongoing relationships and re-engaging with life. While that may be true, Dr. Chilly also noted that the Appellant's serial losses contributed to her profound discouragement and depression and that her symptoms have compromised her mood, cognitive functioning, interpersonal relating and adaptability to stressors. The Tribunal finds that, to the extent the Appellants' depressive mood, poor cognitive functioning and poor adaptability to stressors interfere with her capacity regularly to pursue any substantially gainful occupation, the treatment offered by Dr. Chilly is the first step in the process required to address those losses which compromise her function, including her employability.

[72] The Appellant has attributed significant mental fog to her medication. The Tribunal has not been provided with medical evidence which, on balance, supports a finding that the side-effects of medication have caused the cognitive fog that the Appellant repeatedly described in her oral testimony. Although Dr. Domitrovic noted that medication monographs indicate that headache can be a side-effect of Aggrenox, and headache and lightheadedness a side-effect of Lipitor and Amlodipine, she also stated the most recent review of drug induced stuttering she could locate did not implicate the Appellant's current medications. She also stated that

pharmacological treatment of the Appellant's sleep disturbance and emotional lability may increase her sense of well-being and diminish her phenomenology of cognitive inefficiency to some extent. The Tribunal also notes that Mr. Thacker recommended that the Appellant's physician arrange for her pharmacist to rule out any relationship between her medications and drugs known to be associated with stuttering, impaired verbal or reading recall, impaired listening and reading comprehension or word finding. The Tribunal has not been provided with a pharmacy report addressing this issue and supporting any association between medication and stuttering, impaired verbal or reading recall, etc. Also, according to Dr. Chilly in her September 2013 report, the Appellant's compromised cognitive functioning appears to be related to her losses, which treatment was designed to address.

[73] The medical record supports a finding the Appellant has sleep apnea. The Appellant testified she has had difficulty adjusting to nasal prompts and face masks. However, the Tribunal has not been provided with an updated report from Dr. Rodriguez indicating any measures to address these difficulties and the benefits nasal prompts have provided when used. The Tribunal is not satisfied based on the existing medical record that the Appellant's sleep apnea is not relatively well controlled on CPAP or that further adjustment would not be possible upon follow-up with Dr. Rodriguez.

[74] The Tribunal notes the medical record also supports a finding that the Appellant's sleep difficulties are also partially attributable to her sense of loss. For example, in her September 2013 report, Dr. Chilly stated the Appellant conceded to experiencing appetite, weight, **sleep changes**, as well as other depressive signs since the loss of her younger brother. As previously explained, the Tribunal is not satisfied the Appellant has reasonably pursued treatment with Dr. Chilly. (emphasis added).

[75] The Appellant testified she has psoriasis and was recently diagnosed with psoriatic arthritis in 2013 which affects her joints and knees. She was recently put on Methotrexate which gives her headaches for about two days and which causes her to become bloated. The Tribunal notes the Appellant was previously able to work with psoriasis and went off work due to the TIA type episodes, not psoriasis. In terms of psoriatic arthritis, the Tribunal has not been provided with any medical reports concerning this condition including diagnosis and prognosis. The

Tribunal notes the Appellant will shortly see a specialist and will discuss change of medication given the side-effects she experiences while taking Methotrexate. The Tribunal is not satisfied based on the existing medical record and Appellant's testimony that these condition were severely disabling at the MQP or that treatment efforts have been exhausted in terms of psoriatic arthritis.

[76] The Tribunal also notes that psoriatic arthritis in terms of joint impairment would not prevent the Appellant from performing sedentary work. Although the Appellant mentioned joint problems including her knees and wrists, she testified she is able to drive up to 3 times weekly, albeit for short periods of time, on account of issues involving concentration. She did not mention any difficulties with driving on account of issues affecting her knees and wrists.

[77] The Tribunal is further not satisfied the Appellant's weight gain secondary to lack of mobility would affect her capacity to perform sedentary weight.

Prolonged

[78] Having found that the Appellant's disability is not severe, it is not necessary to make a determination on the prolonged criterion.

CONCLUSION

[79] The appeal is dismissed.

Jeffrey Steinberg
Member, General Division - Income Security