Citation: *S. N. v. Minister of Employment and Social Development*, 2015 SSTGDIS 111

Date: October 1, 2015

File number: GT-125851

GENERAL DIVISION - Income Security Section

Between:

S. N.

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 Teleconference on August 26, 2015

REASONS AND DECISION

PERSONS IN ATTENDANCE

S. N., the Appellant

F. N., the Appellant's representative

INTRODUCTION

[1] The Appellant's application for a *Canada Pension Plan* (CPP) disability pension was date stamped by the Respondent on March 20, 2012. The Respondent denied the application initially and upon reconsideration. The Appellant appealed the reconsideration decision to the Office of the Commissioner of Review Tribunals (OCRT) and this appeal was transferred to the Social Security Tribunal (Tribunal) in April 2013.

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

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

b) 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, 2009.

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

EVIDENCE

[9] On March 20, 2012, the Respondent date stamped received the Appellant's Questionnaire. She stated she completed Grade 13 and nursing school where she obtained her registered nurse diploma. Her most recent job was as a medical surgical intensive care nurse at S. M. Hospital in the Medical Surgical Intensive Care Unit (ICU). Those job duties started on April 4, 1977. She stopped working due to a diabetic foot ulcer. In an amended Questionnaire dated April 29, 2012, she indicated she stopped working on September 29, 2006. She specified she could no longer work as of October 3, 2006. She described the illnesses or impairments which prevented her from working as i) right below knee amputation, ii) diabetic neuropathy and iii) insulin dependent diabetes. She states she has limited stamina and that circulation in her remaining leg is very poor. She also described hypertension (on medication) partial thyroidectomy (on medication), enlarged mediastinal lymph nodes and sarcoidosis – Stage 1.

She stated that sitting/standing is variable and that she has difficulty with pain on standing stationary for a few minutes. She has purchased a power lift reclining chair and requires an extended toilet seat. She requires right leg prosthesis and uses two canes to walk. She can only carry a purse over her shoulder when walking. She uses a grabber for reaching. She has difficulty bending and uses a seat for bathing. She requires assistance dressing and a commode at her bedside. She has difficulty standing in one place preparing meals. She supports herself with a grocery cart while grocery shopping and requires her spouse's assistance. She is prescribed Insulin, Levothyroxine, Diltiazem, Pantoprazole, Candesartan, Gabapentin, Aspirin, Tylenol and Crestor. She has seen a dietician and the diabetes clinic resource nurse. She has an artificial limb, uses a wheel chair, canes and a rollator.

[10] On April 29, 2012, the Appellant completed a second Questionnaire. She stated she stopped working on September 29, 2006 due to diabetic foot ulcer. In response to Question 30: 'If considered suitable, would you consent to a vocational rehabilitation assessment', the Appellant responded 'Yes' and stated: "Needs to be sedentary".

[11] In her Reconsideration request, the Appellant states that problems with her foot began in 2006 secondary to her diabetes and circulatory problems. In June 2005, she developed a diabetic foot ulcer. At the time, she was working full time 12 hour shifts as an RN in the intensive care unit at S. M. Hospital. Under medical care, she was on and off work. The ulcer would heal but break down when she would wear shoes or with prolonged standing. She was treated by debridement, dressings, air cast x2 and orthotics. After her sick time ran out, she was placed on modified work for about 9 months but continued to have problems. In the fall of 2006, her employer gave her the choice to quit, return to work full time or retire. She chose to take an unpaid leave of absence for seven months until she turned 55 in order to qualify for early retirement. She stated that problems with her feet have been a recurring issue and that control of her blood sugar and fatigue have been a continuing common problem. Apart from diligent self-care, she was treated at the wound/foot care clinic at S. M. Hospital for foot ulcers. In December 2010, she developed a significant foot ulcer that required emergency debridement. For the next six weeks, she dressed changes on her right foot. It appeared to heal well however she subsequently became nauseous. She returned to Emergency, was hospitalized, became seriously ill with diabetic gangrene and required a below the knee amputation of her right leg on February

19, 2011. She continues to have problems with her blood sugars and insulin with symptoms approaching hypoglycemic unawareness. She is further concerned about the health of her left leg and stump.

[12] In an October 20, 2012 letter to the Respondent, the Appellant stated she has had ongoing problems with her feet. She withdrew from the workforce in 2006 with an unpaid leave of absence until she turned age 55 and could take early retirement. Her ongoing medical problems culminated in a right knee below amputation in 2011, which is both severe and prolonged. The cumulative effects of her amputation are challenging. In terms of ordinary everyday chores, her mobility is markedly restricted.

[13] In her letter of appeal to the OCRT, the Appellant states she did not feel her medical condition which led to amputation has been fully understood. She worked in intensive care at S. M. Hospital for as long as her condition (diabetic foot ulcer) allowed. The condition that led to amputation of her right leg was a consequence of her diabetic neuropathy and poor circulation that manifested itself in 2005 with a diabetic ulcer on her right foot. With numerous attempts at working, rest (sick days) and a modified work program, the ulcer would appear to slowly heal and then break down under stress. In late 2006, it became apparent to her and her employer that as her career required long hours on her feet and a high energy level, she needed to take an offer of early retirement after a six month unpaid leave of absence until she turned age 55 (to be eligible for her reduced pension). Prior to the amputation, she accompanied her son and husband to Florida and California. She felt not to go and remain at home alone would not be wise given her medical responsibilities. She knew how to observe and monitor her condition and her spouse was a wonderful support.

[14] On February 27, 2012, Dr. Harrington, orthopaedic surgeon, completed the CPP Medical Report. He stated he knew the Appellant since March 2011. He diagnosed insulin dependent diabetes mellitus, right below knee amputation February 17, 2011 and peripheral neuropathy left leg. He indicated she would require a prosthetic and follow-up stump care. He stated that due to her history of insulin dependent diabetes resulting in right below knee amputation, her long term prognosis was uncertain. He stated she would continue to be followed at the TEGH amputee clinic every six months.

[15] According to an October 31, 2005 Ambulatory Record, the Appellant's diabetes was poorly controlled. She had a callus which was debrided and was fitted with an air cast. The same day, Dr. Mahoney, Wound Management Ambulatory Consult, reported he saw the Appellant for her right great toe plantar wound. He noted she had difficulty for a number of months and reported some episodes of redness and discomfort extending up above the knee level. He stated she was admitted on account of her diabetes, which was not well controlled. Her hyperkeratosis was debrided. He recommended offloading of her forefoot to facilitate healing. She was fitted with an Air cast. For the long term, she would need to be fitted with offloading to the great toe.

[16] According to a November 22, 2005 Ambulatory Record, the Appellant had a history of a right 1st toe wound. The plan was to provide wound care, air cast and insoles. According to a December 6, 2005 Ambulatory Record, the wound had resolved.

[17] On September 7, 2006, Dr. Zownir, internal medicine, reported the Appellant was seen in follow up for her diabetes, hypertension and previous diabetic foot ulcer of the right foot. He stated she had some difficulty maintaining her weight (213 lbs). Her further noted she had been working three half days a week in ICU as administrator and very little time at bedside. Her major complaint was refractive fatigue which provoked her inability to maintain any prolonged work schedule. She denied any chest pain, shortness of breath, orthopnea or PND, but "tends to fatigue easily and is relatively tired with her half days". She had some right lower leg discomfort at times, which transmitted to the right hip and back. Her extremities revealed well-healed previous right big toe diabetic ulcer. She was advised to continue with the same regimen of medical management. Dr. Zownir wrote: "..and for the moment we are not increasing her work schedule as she doubts that she could handle a bigger load in 4 hours 3 times a week."

[18] According to a June 26, 2007 Ambulatory Record, the Appellant had a left 1st toe wound with duration of about four weeks. Necrotic tissue was debrided after cleaning. The Appellant indicated she wanted to swim in Muskoka. She was advised to avoid wearing swimming shoes. She was also advised to see a chiropodist to reassess orthotics and for callus debridement before taking a trip to Russia in August 2007.

[19] On December 20, 2007, Dr. Zownir reported the Appellant has traditionally run high blood sugars. Her recent blood work supported this with an elevated hemoglobin A1C. He again

endorsed optimization of diet, weight and activity level. Her insulin was increased. She had concurrent hypertension controlled with medication. Her blood pressure was acceptable and lung fields clear. She would be seen in 3 months' time.

[20] On April 17, 2008, Dr. Zownir reported that the Appellant's blood sugars had been somewhat erratic due to her work, her schedule and her travels. She had virtual healing of her previous diabetic ulcers of her feet. She was encouraged to remain active as best tolerated in an effort to lower her blood pressure (138/78).

[21] On July 24, 2008, Dr. Zownir reported the Appellant was doing well in overall status. According to Dr. Zownir, although her blood sugars had been "sporadically" varied so had her activity. He also stated: "She is somewhat lax with her compliance to diet".

[22] On October 16, 2008, Dr. Zownir reported the Appellant was seen for development of a superficial ulcer on the plantar surface of her left heel. She had been travelling locally applying some salt water baths and had an appointment at the Foot Clinic on October 28, 2008. Presently, her blood sugars were somewhat erratic. She had a small ¾ inch length superficial crevice ulcer on the plantar surface of the left heel which would be treated with saline soaks, ointment and Keflex.

[23] According to an October 28, 2008 Ambulatory Record, the Appellant had a persistent foot ulcer which began on Thanksgiving. Her blood sugars were "up until 20s". Her wound was debrided.

[24] On October 29, 2008, Dr. Zownir reported the Appellant was assessed in the chiropody foot treatment and assessment clinic the previous day for treatment of her left foot wound. She indicated that her blood sugars were regularly elevated, at times in the 20 mmol range. She recently developed a small wound upon removal of some loose skin. An ulcer was located on the plantar-lateral aspect of her left distal heel. Callus surrounding the wound was debrided. Dr. Zownir discussed the negative effect of elevated blood sugars on wound healing. He indicated he planned on follow up with her in 5-6 weeks' time since she was planning to travel in the near future.

[25] According to an Ambulatory Record report dated 2008 -12-02, the Appellant just got back from Florida and was planning to return in the near future. It was noted her left lateral heel wound had healed and callus was present. There were zero signs of infection.

[26] On February 12, 2009, Dr. Zownir reported that skin involvement of the Appellant's feet had improved. She was maintained on insulin. Her blood pressure was 130/76 and lung fields were clear.

[27] On May 7, 2009, Dr. Zownir reported the Appellant had generally enjoyed excellent health since her last visit in February 2009. She was asked to continue on her current regimen of medical management and would be seen in 3-4 months' time.

[28] On August 6, 2009, Dr. Zownir reported the Appellant did not have any problems with hypoglycemia. He stated that sporadically, she would run high which was explained by injudicious use of diet. The Appellant reported she recently developed musculoskeletal aching which tended to involve the quadriceps of both legs, more right than left and in the extensor muscles of her upper extremities, again more marked right than left. On physical examination, he could not find any focal deficits. She had good range of movement and no sensory deficits other than a vague stocking distribution hypoesthesia of the lower legs. Her tendon reflexes were brisk and she had good range of movement with good muscle strength. She was advised to increase her level of physical activity as tolerated.

[29] On November 12, 2009, Dr. Zownir reported the Appellant's sugars were running rather erratic at times. She had some panic attacks but otherwise denied palpitations of significant, chest pain or orthopnea. She was relatively inactive and was encouraged to increase her level of activity.

[30] On February 11, 2010, Dr. Zownir reported that the Appellant (57 year old retired RN) was seen in follow up. He noted her sugars had been slightly erratic but were generally acceptable and that she had lost weight in an effort to optimize her blood sugars. He stated she was a compliant patient who had no difficulty adhering to her regimen. She had a little bit of hematoma from a traumatic stubbing of her right toe, which he believed was resolving. He stated: "Otherwise, she has maintained generally good health and has been traveling to Florida,

California, as always, has had no significant symptoms other than slight nausea in the morning over the last 2 or 3 days but no fever, chills, rigors, changes in colour of urine or bowel pattern".

[31] On June 3, 2010, Dr. Zownir reported the Appellant had several concurrent problems, including hypothyroidism on replacement therapy, hypertension and gastro esophageal reflux. He stated she "has been active with traveling with her son and she travels the country with her husband and has had somewhat erratic blood sugars but generally overall has been reasonably well controlled". He stated she has not had any significant hypoglycemic episodes but tends to drift higher sugars with poor control. He stated she would be encouraged to be more compliant with diet, activity and continue with her medical regimen as outlined.

[32] On September 13, 2010, Dr. Zownir reported that the Appellant had type 2 insulin diabetes, hypertension, hypothyroidism, gastro esophageal reflux and some degree of peripheral neuropathy. He stated that generally, she was doing well. He stated she has a tendency to be haphazardly erratic but generally had not been in any significant hypoglycemic episodes. Her weight had been stable, she had been active and she did not have symptoms of hypoglycemia. Her blood pressure was 126/70. He noted she would be seen in 3 months' time.

[33] On December 13, 2010, Dr. Zownir saw the Appellant in follow up. He stated she had very few symptoms related to reflux. He indicated that generally, she feels well with her energy level except occasionally feeling stressed with accelerated blood sugars. Her blood pressure was 124/70. He stated he would see her in 3 months' time.

[34] According to a March 7, 2011 S. M. Discharge Summary, the Appellant had presented to the ER on February 11, 20011 with an increasingly painful ulcer on her right fifth toe. She had a history of poorly controlled T2DM but no known retinopathy, nephropathy or coronary artery disease. She was treated, returned home but returned to the ER with fever and nausea. Her condition progressed to wet gangrene affecting the 4th and 5th right toes despite antibiotic coverage. It was determined that a below knee amputation was required. It was noted she would require good diabetes follow up to prevent further complications. Her postoperative course was complicated by an episode of acute shortness of breath on POD2. A pulmonary embolism was ruled out and she was medically managed as an acute coronary syndrome. She continued to have mild shortness of breath and was found to have significant pulmonary edema. She was treated

with Lasix and improved significantly. Follow up echocardiography and MIBI studies were normal. At the time of discharge, she was mobilizing well with the help of physiotherapy. She was started on basal insulin and multiple daily injections. She would require outpatient follow up for management of her diabetes and prevention of further complications.

[35] On March 10, 2011, the Appellant was seen in consultation in the Respirology Clinic. She was referred for assessment of mediastinal and hilar lymphadenopathy with a question of sarcoidosis. It was noted she was admitted to hospital between February 11, 2011 and March 2, 2011 for an ulcer on her right toe which progressed and required below knee amputation. Her postoperative course was complicated by congestive heart failure and a non-STEMI demand-related myocardial infarction. A chest x-ray and CT showed significant mediastinal and hilar lymphadenopathy. She was referred to respirology for assessment of sarcoidosis. The assessing doctor stated she presented with an incidental finding of mediastinal and hilar lymphadenopathy on chest CT scan. She would be further screened and blood work and a repeat CT were ordered.

[36] On March 24, 2011, the Appellant was seen in the Diabetes Clinic. It was noted her blood sugars were being checked 4 times daily at Providence with highly variable readings. She was noted to have had a couple of episodes where she did not feel hypoglycemic with blood sugar levels between 4-6. She had no symptoms of hyperglycemia. She was noted to have significant evidence of peripheral neuropathy with the foot ulcer and neuropathy in the left foot. It was recommended that she continue with her medication, continue checking her blood sugars, continue on a diabetic diet and increase her exercise as much as possible after she received her prosthetic. In terms of vascular protection, her blood pressure was near target. She was to continue her current antihypertensive. In terms of diabetic complications, for neuropathy, she was to continue Gabapentin and see a chiropodist for her left foot care given her high risk of developing an ulcer on that side. The same day, the Appellant was seen in the Respirology Ambulatory Clinic in follow up for possible sarcoidosis. Test results seemed consistent with sarcoidosis stage 1. The assessor elected to follow her and see her again in 3 months with another CT and full pulmonary function tests.

[37] According to a May 11, 2011 Discharge Summary, the Appellant was admitted to Providence Healthcare on March 2, 2011 after undergoing right below knee amputation at S. M. Hospital for peripheral vascular disease and gangrene carried out on February 19, 2011. She was now ambulating and the team felt she was ready for discharge.

[38] On May 25, 2011, Dr. Harrington saw the Appellant in follow up. He stated she was doing well following amputation surgery. Her stump looked well and she was ambulating "quite nicely" and without a cane. She was undergoing outpatient gait training. He stated he would reassess her in six weeks' time.

[39] On May 16, 2011, the Appellant was seen in the Ambulatory Clinic. She was noted to have done well since her right below knee amputation. The assessor stated: "(The Appellant) has generally fared well since her discharge." Her blood pressure was 124/76 and she had clear lung fields. She was to be continued on her current medication and be seen in 6 weeks' time.

[40] On July 11, 2011, the Appellant was seen for an Ambulatory Consult. It was noted she had maintained stable weight and had no specific problems with her prosthesis. Her blood pressure was 118/74 and her lung fields were clear. She was to continue her current line of medical management and be seen in 3-4 months' time.

[41] On July 13, 2011, Dr. Harrington reported the Appellant was doing very well and that her stump looked excellent. He stated she was ready to progress from a temporary to permanent prosthesis.

[42] Dr. Zownir saw the Appellant on October 17, 2011. He indicated she was recently assessed and he reassured her that there was no evidence on her CT of active pulmonary sarcoid. She had been doing well with her new prosthesis fitting on her stump and "has been doing well in regards to her blood sugars as well". He noted her blood pressure was 130/70. She would be reviewed in 3 months' time.

[43] On November 16, 2011, Dr. Harrington reported the Appellant felt a bit unstable walking with her prosthesis. He noted the hospital prosthetist was attempting to make some adjustments to see if it would alleviate her symptoms. She indicated that on occasion she felt an exploding sensation in her left leg. Clinical examination revealed no significant abnormalities

and no evidence of a vascular or ischemic problem. She was to be reviewed in three months' time.

[44] On February 15, 2012, Dr. Harrington reported the Appellant was seen in follow up examination in the Amputee Clinic. Her stump looked excellent. He stated: "She was doing quite a bit of walking and stair climbing recently at a recreational vehicle show and this involved going up and down steps to get in and out of the vehicles. Afterwards, she was aware of some pain and some irritation of the skin at the back of her prosthesis. Her stump looks fine today. There is no difficulty."

[45] On March 5, 2012, the Appellant was seen in the Ambulatory Clinic. It was noted that with close monitoring, her blood sugars had been erratic. The assessor stated: "Overall, she is generally doing reasonably well considering the number of problems, but needs to monitor her blood sugars closely and make any adjustments accordingly".

[46] On April 11, 2012, Dr. Wong saw the Appellant for sarcoidosis. He noted she was last seen in the clinic in July 2011. He stated that since her last visit, she had been doing quite well and denied any new respiratory symptoms. She had somewhat of a sedentary lifestyle. She continued to walk with two canes but denied any new symptoms suggestive of extra pulmonary sarcoidosis. Her repeat CT scan did not appear to demonstrate any significant worsening of her lymphadenopathy and there did not appear to be any evidence of significant pulmonary and parenchymal abnormalities. He stated she had presumed stage 1 pulmonary sarcoidosis that appeared to be stable. He felt it was reasonable to continue to follow her conservatively and follow up in one year's time.

[47] On June 18, 2012, Dr. Zownir reported the Appellant had "ballooned" in terms of weight gain – 60 lbs. in the past year. She had developed some discomfort in the posterior aspect of her right leg in the region of the popliteal fossa, with some discoloration and swelling. He could not palpate any significant swelling in the right popliteal fossa. She had good excursion and range of movement of the right knee and there was no effusion. He indicated she would be seen in three months' time.

[48] On March 24, 2014, the Appellant and her spouse sent a letter to the Tribunal criticizing the Respondent's handling of her application. They disputed the assertion that her amputation was simple, given that she required 4 months' recovery from the infection that necessitated surgery. During hospitalization, the doctors discovered she had sarcoidosis. They further reject the Respondent's position that she should have continued working in any capacity with recurring diabetic foot ulcers. They state the ulcers would not have healed and would have culminated in a right foot amputation in any event. In terms of her travels after retirement but prior to amputation, she had the opportunity to follow their son who was on the Canadian sailing team and campaigning for the Olympics. She had nothing to do except rest and recuperate from the recurring diabetic foot ulcers. They stayed in motels and ate in restaurants. They stated it is incredulous she is being punished for travelling after her health forced her to retire early before her amputation.

[49] On June 18, 2015, the Appellant's representative submitted that the Appellant had frequent recurring diabetic foot ulcers since her first in 2005. She had worked with a modified work schedule but the ulcers would occur or reoccur on either foot, which would require her to totally rest her feet. The ongoing problems were taxing and exhausting. The ulcers required two to three months rest, very limited mobility and air cast and precluded her from doing any job as her health absences rendered her unable to hold any job. Even with all this care, on February 19, 2011, as a result of infection of a diabetic foot ulcer, her right leg had to be amputated below the knee. If she could have held a job during that time, it is apparent she would have lost her leg sooner.

Oral Testimony

[50] She started to work as a nurse in September 1973 at S. M. hospital. Her graduation ceremony was the Sunday in Convocation Hall and she started to work on the Monday.

[51] She worked on an all-male surgery floor and went to other floors including general surgery (private), urology, and acute care. She started working in the ICU in or around 1977.

[52] She started to work in modified duties starting in or around January 2006. She performed this work until approximately September 2006. During that period, she had different hours. Eventually, they were decreased and she ended working two hours three times weekly. Her spouse had to drive her to work and pick her up due to her foot. She had difficulty with stairs. She was exhausted but it was more than that. Her job consisted of reading manuals. At times, the employer tried to have her perform nursing duties in ICU but she could not perform them. It was too much for her and she could not tolerate it. She could not be on her feet and was suffering from fatigue.

[53] When the employer told her to quit, retire or return to work, she understood this to mean to return to ICU full-time.

[54] In terms of Dr. Zownir's comment in September 2006 that she was working 3 half days a week in ICU and could not handle a bigger load in 4 hours 3 times a week, she states she probably tried working those hours. However, her work hours were reduced to 2 hours 3 times a week. There was a difference between what they wanted her to work and what she was capable of doing. A lot of the time, she was officially at work two hours. She was also off work a lot of the time. Her attendance was very "sporadic". Her foot would break down or she felt too sick. She contributed $548.21 to CPP in 2006 in contrast to her much larger 2005 contribution of $1,861.20. Some days she did not feel she could complete the shift as her foot would hurt or she was not feeling well. Other days, she might be scheduled for work but was unable to go in. She tried her absolute best to get back to full-time work. She felt sick and exhausted.

[55] In terms of carrying out her activities of daily living in December 2009, her ability would depend upon how she was doing day to day. One day she could be "so-so"; another day her sugars could be out of "whack"; one day, her feet could be okay; another day she could wake up with blood all over her foot. Something could happen to the foot and she would not even know.

[56] She always tried her best. She never "slacked off". She would push herself and wanted to do the best for her patients. She did not think she could provide good care because she felt too sick. At times, she felt she needed more care than the person she was looking after. She stated: "Who chooses to take a leave of absence for six months with no pay to go onto a reduced

pension". She stated that people do not choose that unless they are forced into it. The employer did not give her the option of continuing her modified work duties. If they gave her that option, she probably could not have continued in the job. She was exhausted. Her foot would break down.

SUBMISSIONS

[57] The Appellant's representative provided lengthy and detailed oral submissions. The main points in support of his position the Appellant qualifies for a disability pension are as follows:

a) Type II diabetes is a chronic condition. One side-effect is poor circulation which can result in problems with feet. She was in remission on December 31, 2009 and had not had a recurrence of her foot ulcer since the prior year. The fact she did not have problems with her feet in December 2009 is only a "matter of a calendar". She has a chronic condition. She suffered a recurrence in 2011 at which time she lost her leg resulting from her chronic condition.

b) She was an ICU nurse with specialty knowledge of wound care. Despite that, she still was unable to control her condition.

c) The amputation is a direct connection to her diagnosis of diabetes in 1995. The fact she did not have a diabetic foot ulcer in 2009 is only a matter of remission or "fortunate accident".

d) She did not have to do anything after she stopped working. He cared for her so she would not stress her foot.

e) She did not have a simple amputation. She was in the hospital until March 2, 2011 (two weeks after the amputation) and in rehab for over two months. She then required two months physiotherapy. She also has sarcoidosis and was short of breath. Fortunately, it has not gotten worse.

f) She has a continuing chronic disease first diagnosed in 1995 with progression. She cannot walk well and has limited movement.

g) She had a thyroidectomy and takes medication.

h) She paid into CPP for 36/37 years yet one talks about 3 years (presumably referring to the MQP calculation). She thought her contributions would protect her if she had a problem.

i) Diabetes is a chronic illness. She will never be free of it. She was not obese when she was first diagnosed with diabetes. People performing shift work are more likely to develop diabetes. One side-effect is foot ulcers. Her remission in December 2009 did not mean she did not have diabetes or would not suffer a recurrence. She did, in fact, suffer a recurrence.

j) The representative read definitions of chronic disease, type II diabetes and remission into the record.

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

a) The Appellant was 59 at the time she applied for a CPP disability pension. She has a college education and was employed as a nurse until she stopped working in September 2006 due to a diabetic foot ulcer. She claims that diabetes, a right below the knee amputation and diabetic neuropathy rendered her disabled.

b) She was seen in follow up for her diabetes, hypertension and previous diabetic foot ulcer (Dr. Zownir – Sept 7, 2006). Her main complaint was refractive fatigue, which affected her ability to maintain a prolonged work schedule.

c) She appeared well and her previous right toe diabetic ulcer was well healed. She was advised to optimize her diet, weight and activity level. Her insulin was increased (December 20, 2007).

d) Her blood sugars were noted to be somewhat erratic due to her work, her schedule and her travels (April 17, 2008). Her feet were “entirely clear of any breakdown” or ulceration.

e) She developed a superficial ulcer on the left heel treated with saline soaks, ointment and an antibiotic (October 16, 2008). She was seen by a chiropodist (October 29, 2008) and her ulcer was debrided. She was advised to continue with wound care and wear her orthopedic shoes.

f) Her foot improved (February 12, 2009) and the internist noted she had "enjoyed excellent health since her last visit" (May 7, 2009).

g) She presented with musculoskeletal aching involving her legs, however there were no focal deficits noted. She had good range of motion, good pulses, good muscle strength and no sensory deficits (August 6, 2009).

h) She had maintained generally good health and had been travelling to Florida and California. Her blood sugars had been somewhat erratic but were generally reasonably well controlled (June 3, 2010). She continued to travel the country and was encouraged to be more compliant with her diet, activity and medical regime.

i) She presented to the hospital on February 11, 20011 with an increasingly painful right toe ulcer (March 7, 2011). She was treated with antibiotics but her condition progressed to gangrene requiring a below knee amputation. She was sent for prosthetic fitting (March 11, 2011), her stump looked excellent and she was ambulating quite nicely with and without a cane. She was doing quite a bit of walking and stair climbing (February 15, 2012).

j) She must be deemed incapable of all work as of December 2009 and continuously since. Her medical conditions are acknowledged. She was not disabled from all work as of December 2009. She was under the regular care of specialists from 2005 onward. There is no indication of any severe disabling condition in December 2009. Her amputation which occurred in February 2011 is after the date she last qualified for benefits.

ANALYSIS

Severe and Prolonged

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

[60] The Tribunal is satisfied given the Appellant's recurrent foot ulcers that she was incapable of working full or part- time as an RN in the ICU, which required her to be ambulatory.

[61] That leaves the question whether the Appellant could perform other non-ambulatory work either on a full or part-time basis.

[62] The jurisprudence requires an applicant for CPP disability benefits to demonstrate that he or she is incapable regularly of pursuing not only his or her previous work but also any other substantially gainful occupation including lighter or sedentary work on either a full or part-time basis.

[63] In this regard, the Tribunal notes that between January 2006 and September 2006, the Appellant was placed on modified duties. According to the Appellant, she was reading manuals. She was unable to be more specific as to her job duties. She states she was also asked to perform ICU nursing duties but was unable to do so. She states she worked 3 days a week. Although she may have tried working four hour shifts, it is her recollection that her hours were reduced to two hour hours per shift, although she could not be specific as to when this happened due to the passage of time. She states her attendance was very sporadic. Some days, she came in and could not function. Other days, she could not attend the workplace. She felt sick and exhausted.

[64] In her Reconsideration request, the Appellant stated that in the fall of 2006, her employer gave her the choice to quit, return to work full time or retire. In her letter of appeal to the OCRT, she stated that in late 2006, it became apparent to her and her employer that as her career required long hours on her feet and a high energy level, she needed to take an offer of early retirement.

[65] Although the Tribunal is satisfied the Appellant was unable to return to her previous full time ambulatory job as an RN in the ICU, it is not satisfied she was incapable regularly of continuing to perform her modified part-time work as administrator in ICU or other work of a sedentary nature.

[66] The Tribunal notes the Appellant left her part-time job and took early retirement not because she was unable to continue performing her modified job duties but because of the election to which her employer put her which involved quitting, returning to work full-time in the ICU or retiring. Based on the limited evidence before it, the Tribunal is unable to characterize the Appellant's period of modified work as a failed work effort.

[67] Although the Appellant states she was sporadically absent from the job, the Tribunal finds that between January and September 2006, she was capable of performing sedentary work which consisted of three four hour shifts a week. Although the Appellant states her hours were reduced to two hour shifts, the Tribunal prefers Dr. Zownir's contemporaneous report of September 7, 2006 in which he clearly stated she had been working 3 half days a week in the ICU as an administrator. He further wrote: "and for the moment we are not increasing her work schedule as she doubts that she could handle a bigger load in 4 hour 3 times a week." Given the specificity of Dr. Zownir's comments and the contemporaneous nature of his report, in contrast to the Appellant's lack of specificity as to when her hours were reduced or the period of time she actually tried to work four hour shifts, the Tribunal finds that Dr. Zownir's report likely constitutes the more accurate description of her work schedule at the time she stopped working.

[68] In any event, the Tribunal is satisfied that the Appellant's capacity to attend work three times a week between January and December 2006 with earnings of $14,575.00 during that period is evidence of capacity regularly to pursue a substantially gainful occupation. Although she was not earning her previous regular full-time income, the Tribunal finds that her remuneration relative to her hours worked was not merely nominal, token or illusory compensation, but compensation that reflected an appropriate award for the nature of the work performed. Also, given the Appellant's limited description of her modified job duties during her oral testimony, the Tribunal is unable to make a finding that the nature of the work performed

was for a benevolent employer or was not reflective of job duties required of an employee in the competitive labour market.

[69] The Tribunal is aware of the fact that after the Appellant stopped working and took early retirement but before the MQP, she had some ongoing issues with her feet and blood sugars. For example a June 26, 2007 Ambulatory Record reported a left 1st toe wound of about four weeks duration. In October 2008, she was seen for development of a superficial ulcer on the plantar surface of her left heel. Her blood sugars had also been somewhat erratic or sporadically varied. She was seen in late October 2008 for a persistent foot ulcer which began on Thanksgiving. Her blood sugars were in the 20s.

[70] However, the medical record does not uniformly and consistently describe ongoing high blood sugars and problems with the Appellant's feet on an ongoing basis during this period of time.

[71] For example on May 7, 2009, eight months prior to the MQP, Dr. Zownir reported that the Appellant had generally enjoyed excellent health since her last visit in February 2009. In August 2009, five months before the MQP, he stated she did not have any problems with hypoglycemia and reported she sporadically would run high explained by injudicious use of diet. In this regard, the Tribunal notes that the word 'sporadic' connotes an occurrence taking place at irregular intervals or only occasionally. Although the Appellant also reported some musculoskeletal aching, Dr. Zownir could not find any focal deficits on physical examination, stated she had good range of movement and muscle strength and advised her to increase her level of physical activity as tolerated. In November 2009 shortly before the MQP, he noted her sugars were running erratic at times. In February 2010, shortly after the MQP, Dr. Zownir stated her sugars had been slightly erratic but were generally acceptable. He stated that apart from a little bit of a hematoma from a traumatic stubbing of her toe, which he believed was resolving, she had maintained generally good health. Again, in June 2010, he described somewhat erratic blood sugars but indicated that generally, overall the Appellant's blood sugars were reasonably well controlled.

[72] The Tribunal is not satisfied that the medical record supports a finding that the Appellant's sporadic or erratic high blood sugars or intermittent problems with her feet were of such severity that they rendered her incapable regularly of pursuing sedentary work, if only on a part-time basis, at the MQP.

[73] The Appellant's representative contends that the Appellant's diabetes is a chronic condition. Her circulatory problems result in recurrent diabetic foot ulcers. Although she did not suffer any diabetic foot ulcers in 2008 or at December 31, 2009, she did suffer a recurrence in 2011, which resulted in amputation. The fact she did not suffer any diabetic foot ulcers at the MQP does not change the fact that her disability is both chronic and recurrent.

[74] The Tribunal accepts the representative's argument that the Appellant's diabetes is a chronic condition and further accepts that she suffers recurrent diabetic foot ulcers. The Tribunal is satisfied, therefore, that her condition is prolonged. However, the question before the Tribunal, given the MQP date and definition of severity in the CPP, is whether the Appellant's disability was both severe and prolonged at the MQP.

[75] For the reasons as set out above, the Tribunal is unable to conclude that the Appellant was incapable regularly of pursuing sedentary work, if even only on a part-time basis, at the MQP.

[76] The Tribunal has also considered the question of the Appellant's diagnosis of sarcoidosis and finds it did not result in a severe disability on or before the MQP. The Appellant's post- operative course was complicated by an episode of acute shortness of breath. Test results in March 2011 were consistent with sarcoidosis stage 1. This occurred post MQP. The Tribunal also notes that on October 17, 2011, Dr. Zownir indicated there was no evidence on CT of active pulmonary sarcoid.

[77] The Tribunal does not question the Appellant's decision in deciding to take unpaid leave and applying for early retirement benefits, given her inability to return to full-time duties as an RN.

[78] However, for the purpose of CPP disability eligibility, where there is evidence of residual work capacity, a person must show that effort at obtaining and maintaining employment has been unsuccessful by reason of the person's health condition (*Inclima v. Canada* (A.G.), 2003 FCA 117).

[79] The Appellant took early retirement and did not pursue other light sedentary work or seek retraining for work within her physical restrictions, which would require her to avoid ambulatory work given her recurrent diabetic foot ulcers. Consequently, the Tribunal finds she has not demonstrated that her effort at obtaining and maintaining employment has been unsuccessful by reason of her health condition at the time of the MQP.

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

[81] Although the Appellant was age 57 at the MQP, the Tribunal finds, given her education and work history, including her capacity to perform what she described as reading manuals in administration in ICU, that she possessed transferable work skills which would support her efforts to find alternative work or retraining.

[82] Although the Appellant's circumstances are extremely sympathetic and she may well now be disabled as defined in the CPP following her 2011 amputation, the Tribunal is constrained by the legislation and is required to consider the Appellant's condition at the MQP.

[83] For the above reasons, the Tribunal is unable to conclude that the Appellant's disability was severe as defined in the CPP at the MQP

CONCLUSION

[84] The appeal is dismissed.

Jeffrey Steinberg
Member, General Division - Income Security