Citation: ***K. I. v. Minister of Employment and Social Development*****, 2015 SSTGDIS 135**

Date: December 3, 2015

File number: GP-13-2978

GENERAL DIVISION - Income Security Section

Between:

K. I.

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 December 2, 2015

REASONS AND DECISION

PERSONS IN ATTENDANCE

K. I., the Appellant

Gabriela Nowicka, the Appellant’s legal representative

Jacek Kozak, Polish-English interpreter

INTRODUCTION

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

[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) This method of proceeding 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] There was no issue regarding the MQP because the parties agree and the Tribunal finds that the MQP date is December 31, 2014.

[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.

EVIDENCE

[8] On September 18, 2012, the Appellant completed the Questionnaire. She stated she completed Grade 12. She had worked between September 1, 2008 and September 25, 2009 as a salesperson at Polcan Meat and Deli. She stopped working due to a motor vehicle accident (MVA) which took place on September 27, 2009. She states she could no longer work as of that date. She listed her conditions as post-traumatic stress disorder (PTSD), fibromyalgia, chronic lumbar disc disease, microprolactinoma and chronic pain syndrome. She stated that as a result of her conditions, she cannot walk, sit or stand longer than fifteen minutes. She cannot bend, rotate, carry, lift, change position or walk up stairs. She described severe headaches, leg pain, swelling, numbness, tingling in her body, insomnia, groin pain, pinching, burning, limping, back pain, shoulder pain, pelvis/ pubis/ bladder and abdomen pain. She further described numbness in her buttocks and perineal area. She stated she is unable to participate in any physical activities such as sports or hobbies or attend social events due to severe pain. She is also unable to perform household maintenance activities. Her spouse does the cooking, cleaning and shopping. She sometimes has difficulties with memory and concentration and is unable to sleep without medication. She drives occasionally for very short distances. She is prescribed Maxalt (for migraines), Lyrica, Nortriptyline, Tylenol 3, Seroquel, Celebrex and Oxycocet. She has had

physiotherapy, massage therapy, acupuncture and osteopathic treatment. She will see a urologist and is scheduled to have a CT (abdomen and pelvis) and MRI (pituitary gland). She is further scheduled to see an endocrinologist. She uses safety rails, a shower chair, a safety step and folding step/stool for the bathroom and kitchen. She would be able to consent to a vocational rehabilitation assessment if her severe pain and symptoms were treated.

[9] In her Reconsideration request of March 7, 2013, the Appellant stated she is in constant pain and that her condition is not improving. Since the MVA, she is unable to work, walk, sit, or sleep. Her mental condition is getting worse as her severe post-traumatic depression develops. She spends entire nights sleepless and in pain. Pain killers help but only for short periods of time.

[10] In her November 6, 2013 appeal to the Tribunal, the Appellant stated she has been unable to do anything since the MVA. She has constantly been on medication for fibromyalgia, such as Tylenol 3, Nortriptyline, Lyrica and Cymbalta. Medication has not improved her condition, which has resulted in her inability to attend any pain program. During the day, she cannot move at all or make commitments to any long-term programs, which require her family members to be present. Having a Polish speaking psychiatrist gives her the chance to speak about her problems freely without the help of a third party. She has major depression in addition to chronic physical pain. Her family doctor managed her pain symptoms for many years. After the MVA, she developed insomnia and mood swings. She cries a lot. She would work if she could. She takes strong medication, feels constant pain and is unable to sleep and perform basic human activities. She cannot do any kind of work, full, part-time, casual or seasonal. She has attended all referred programs, however none were successful. Her doctors state she is a completely disabled person with no chance of recovery. They state her disability is severe and prolonged and that she is unable to perform any kind of work.

[11] On August 4, 2012, Dr. Michalski, family physician, completed the CPP Medical Report. (GD3-48) He stated he knew the Appellant for 22 years and started to treat her for her main medical condition in September 2009. He diagnosed i) Post-Traumatic Stress Syndrome (PTSS) – MVA 09; ii) fibromyalgia; iii) chronic lumbar disc disease; iv) micoprolactinoma; and v) chronic pain syndrome. According to Dr. Michalski, since the MVA 09, the Appellant has been suffering from a significant impairment involving her activities of daily living (ADL) and chronic pain syndrome in spite of prolonged treatment. She did not improve but deteriorated and

became permanently disabled. She is unable to sleep and takes multiple medications to control pain and insomnia. She walks with difficulty and is unable to sit or stand longer than 15 minutes due to pain in her legs, pelvic and perineal areas. Her spouse cooks, shops and helps her with dressing and bathing. On physical examination, there is diffuse tenderness in both legs, pelvis, gluteal areas and both shoulders. Movements in the lumbar and cervical spine are painfully restricted. She is prescribed Lyrica, Nortriptyline, Maxalt, Tylenol, Oxycocet, Celebrex, and Seroquel. She had no response to treatment and was deteriorating. Under Prognosis, Dr. Michalski stated: "Very poor, high degree of pain, paresthesia in different parts of her body. Pt frustrated by a lack of progress in treatment. Unable to function on daily basis. Needs help in activities of daily life". He added: "Permanently disabled due to severe chronic pain syndrome".

[12] On March 28, 1990, Dr. Higgins reported that the Appellant had been amenorrheic since 1987. She had galactorrhea since then also. On physical examination, she looked perfectly normal. He stated there was a very strong possibility she had a prolactinoma.

[13] On May 16, 1990, Dr. Chan writing for Dr. Higgins reported that the Appellant was admitted on 2/5/90 for pituitary transsphenoidal surgery. Since discharge, she had been feeling well. There was no galactorrhea. He arranged a triple bolus test to assess her residual pituitary function.

[14] On June 12, 1990, Dr. Muller, neurosurgery, saw the Appellant, who underwent transsphenoidal pituitary adenectomy fashioned on May 2, 1990. She had presented with a history of headaches and amenorrhea and a history of some galactorrhea. CT revealed a pituitary mass lesion with suprasellar extension. He stated her subsequent prolactin levels and follow up CT would be an indicator of recurrent or residual disease. He noted that clinically, she felt well.

[15] On January 10, 1996, the Endocrine Clinic reported the Appellant had a transsphenoidal pituitary resected in May 1990. At that time, she had presented with high prolactin levels, amenorrhea and galactorrhea. The most recent MRI from March 1994 showed a nodule on the right side of the pituitary gland. The pathology report obtained postoperatively showed only normal pituitary tissue.

[16] A January 15, 2002 bilateral breast ultrasound revealed cysts and a fibro adenoma on the right breast.

[17] A January 29, 2003 bilateral mammography and bilateral breast ultrasound revealed multiple benign cysts. A large fibro adenoma was not seen on the examination.

[18] An October 29, 2004 right hand ultrasound revealed sonographic features consistent with a hematoma.

[19] A March 1, 2005 ultrasound of both breasts revealed several cysts. No other abnormality was evident.

[20] A December 13, 2005 MRI of the lumbar spine revealed a tiny central disc herniation at L5-S1. There was no spinal stenosis or nerve root compression.

[21] A January 9, 2007 Upper GI series revealed a hiatus hernia with reflux.

[22] A February 13, 2007 Pelvic ultrasound revealed a uterine fibroid.

[23] On April 18, 2007, Dr. Goguen reported she saw the Appellant in the Endocrinology Clinic for her hyperprolactinemia (condition of elevated serum prolactin). She had been off her Bromocriptine therapy since December 2006. She denied any galactorrhea or visual symptoms. She had the occasional headache. She had developed several breast cysts which she described as painful. According to Dr. Goguen, she had a stable prolactin since discontinuing Bromocriptine in December 2996. At that time, there was no evidence of adenoma on her pituitary MRI. There was no indication to resume prolactin suppressing therapy. Her increased fatigue and breast cysts appeared to be unrelated to her previous prolactin issues. Dr. Goguen recommended a repeat MRI in 3 months' time and follow up her prolactin levels in two months.

[24] On April 30, 2007, Dr. Ali reported the Appellant had pituitary adenoma diagnosed 15 years earlier and had been on Bromocriptine which had been reduced recently. She stated her prolactin level had increased. She had pain in the left breast recently. She had been shown to have benign appearing bilateral micro calcifications between 2003 and 2005 and 2006. On September 16, 2006, she had an MRI which showed two nodular densities that had benign MRI features. An ultrasound showed cystic disease. She was asked to confer with her gynecologist and endocrinologist regarding the need for estrogen and Bromocriptine. She was due for another clinical mammographic and ultrasound examination in August 2007.

[25] A July 6, 2007 MRI of the head revealed no appreciate interval change from the previous examination. The findings within the left pituitary gland were suspicious for a residual of a small pituitary micro adenoma.

[26] On May 14, 2008, Dr. Wait, urology, reported he saw the Appellant in 1997 and 2004 with problems related to her bladder in terms of burning during voiding but no hematuria, nocturia, urgency or stress incontinence. He prescribed her an antibiotic.

[27] On August 24, 2009, Dr. Israelian saw the Appellant for EMG and assessment of carpal tunnel. She had been complaining of pain in the neck and shoulder and at times in her palm with some numbness in the second, third and fourth digits. It started in April, was aggravated by work and was better over the weekend. She also complained of some low back pain. In 2005, she had similar complaints, wore splints and got better. According to Dr. Israelian, the EMG study was normal. There was no evidence of carpal tunnel. He stated he believed her pains were mainly due to soft tissue injury sustained as part of repetitive activity. He suggested rehabilitation including physiotherapy. If her pains were to get worse, he suggested that attention be paid to the nature of her work which was aggravating her pain.

[28] An October 6, 2009 abdominal ultrasound was normal (pancreas obscured by gas). The same day, a pelvic ultrasound with transvaginal failed to reveal any significant abnormality.

[29] A December 13, 2009 lumbar spine MRI revealed degenerative disc disease at L5-S1 with a tiny disc protrusion unchanged since 2005 and mild neural foraminal narrowing at L4-5 and L5-S1 bilaterally not significantly changed.

[30] A January 12, 2010 whole body bone scan revealed abnormality of the pubis. It could represent mild diastasis of the symphysis pubis, although there was no evidence of a fracture elsewhere in the pelvis.

[31] A February 21, 2010 MRI of the pelvic girdle failed to reveal any significant abnormality or cause for the Appellants' symptoms of pubis pain.

[32] A May 19, 2010 X-ray left foot and ankle revealed minor osteoarthritic changes of the first metatarsal phalangeal joint (big joint of the big toe) and minor calcaneal spurring.

[33] On July 22, 2010, Dr. James, Rothbart Centre for Pain Care Ltd, reported that he saw the Appellant for main complaints of 1. Groin pain, right greater than left; and 2. Neck pain. He noted she had the groin pain for nine months resulting from an MVA in which she was the restrained passenger involved in a T-bone accident. On a VAS scale, the pain was 7/10. It radiated to the bilateral buttock, hip and right thigh. The pain was made worse by prolonged sitting, standing, walking, flexion and stairs. The neck pain also dated to the MVA. On a VAS pain scale, it was rated 7/10. It radiating to the occiput and temporal lobe (right greater than left). The pain was made worse by night-time sleep. It was relieved by Advil and Tylenol 3.On examination, the Appellant had full cervical range of motion. Gait was within normal limits and sitting posture was stooped. Lower back had reduced lumbar flexion, extension and flexion. Dr. James set out the following impression: 1. Lumbar degenerative disc disease with right L1-2 radiculopathy; and 2. Cervical spondylosis with cervicogenic headache. The differential diagnosis was: 1. Herniated nucleus pulposus; 2. Stenosis; 3. Chronic pelvis pain syndrome; 4. Ilioinguinal/genitofemoral neuralgia; 5. Greater trochanteric bursitis; 6. Sacroilitis; 7. Coccydynia and 8. Piriformis syndrome. He recommended facet diagnostic nerve blocks to the cervical lumbar and sacroiliac areas with possible rhizotomy. GD3-56. He further recommended a trial of Indomethacin for headaches, Topamax for neuropathic pain and headache prophylaxis and a trial of nerve blocks.

[34] On October 20, 2010, Dr. Cheng, physical medicine, completed a Physiatry Independent Medical Examination of the Appellant. GD1-9. According to Dr. Cheng, the Appellant continued to exhibit objective musculoskeletal impairment resulting from the 2009 MVA. He stated the following diagnostic considerations applied: i) diastasis of the symphysis pubis; ii) musculo ligamentous strain/sprain of the cervical and lumbosacral spine; iii) likely strain and/or contusive injury to the distal aspects of the upper limbs bilaterally and the left leg and ankle; and iv) post-traumatic headaches possibly of tension type. He recommended referral to an orthopedic surgeon or pain specialist with expertise in pelvic pain disorders with regard to necessary treatment. With regard to soft tissue injury involving the cervical and lumbosacral spine and distal aspects of the upper/lower limbs bilaterally, he felt the prognosis was excellent for full recovery. He agreed with Dr. Michalski's October 2009 diagnosis of various sprain injuries involving the right inguinal region, upper arm, right knee and right elbow as well as the neck and low back. He did not concur with a diagnosis of lumbar radiculopathy based on his examination findings.

However, he supported diagnoses of post-traumatic headache, residual elbow pain and diastasis of the symphysis pubis. Based on the Appellant's MVA related injury to her pelvis, he anticipated she would be unable to tolerate prolonged standing, walking, sitting to standing transfers, stair climbing and heavy lifting and carrying. He recommended intensive physiotherapy, a pelvic support belt and possible surgical intervention. He stated she suffered an impairment involving her pelvis as a direct result of the likely blunt trauma and/or torsional /rotational injuries sustained during the MVA and would have difficulty tolerating her job duties involving prolonged standing, walking, bending, lifting and carrying. He stated this would render her substantially unable to perform her pre-accident job tasks as salesperson/clerk. Until further diagnostic clarity was obtained regarding the pelvic injury, he did not feel she would be capable of undertaking a graduated and/or modified return to work.

[35] A November 26, 2010 left breast ultrasound revealed benign cysts.

[36] On March 9, 2011, the Appellant was seen in the Endocrine Clinic for her microprolactinoma. She had been off Bromocriptine since 2007 and was not on medication. She had no galactorrhea. She had occasional headaches. A recent MRI of the sella performed on January 1, 2011 revealed a stable lesion in the pituitary gland. The assessor assured her there was no change in the size of her micro adenoma. Prolactin levels drawn the same day were stable.

[37] On April 18, 2011, Dr. Prutis, physical medicine, reported that the Appellant was seen for neck, low back and groin pain. Her diffuse pain in the cervical, lumbar spine and both hips was ongoing. The pain was interfering with her daily activities and sleep. The MRI of both hips was normal. The MRI of the cervical spine did not show disc herniation. An EMG did not show any cervical or lumbar radiculopathy. Dr. Prutis diagnosed chronic mechanical neck pain secondary to MVA. She stated the pain in the groins and lower extremities was likely referred pain from the low back.

[38] An August 5, 2011 diagnostic of the pelvis, taken on account of a clinical history of tender symphysis pubic, revealed a calcific density, which may represent coccyx. The symphysis pubis appeared essentially unremarkable.

[39] On September 15, 2011, Dr. George advised the Appellant that her mammogram did not show any signs of breast cancer.

[40] A September 27, 2011 CT of the pelvis and both hips, taken on account of pelvic pain post-MVA, revealed mild degenerative changes in the region of the symphysis with mild sclerosis and osteophytes, no evidence of fracture of the symphysis, a 9 mm sclerotic lesion in the left superior pubic ramus and sharp angulation between the coccygeal segments 2 and 3 likely related to trauma of indeterminate age.

[41] A November 29, 2011 Cystoscopy revealed local tenderness in the area of the symphysis pubis. Dr. Marcuzzi, surgeon, suspected the Appellant had osteitis pubis (inflammation of the pubic symphysis and surrounding muscle insertions). He stated this usually settles with time but can be a long-term disability. He prescribed Macrodantin.

[42] On February 1, 2012, Dr. Birnbaum, neurology, saw the Appellant for her multiple complaints including problems with her legs (right greater than left) for more than two years, pain in the groin, pubic area and hip and buttock. The pain is intermittent. She has it on a daily basis. It may last up to several hours. It is increased by sitting. She also complained of numbness in the hands for about a year. On the right, it involved the entire hand; on the left, the thumb index and middle finger. She would wake up at night 2-3 times weekly due to hand numbness. She also complained of burning sensation in the eyes for about two months and sometime a burning sensation in the entire body. Her pelvic symptoms started after the September 2009 MVA. A September 2011 CT of the pelvis and hips revealed some degenerative changes in the region of symphysis pubis and sharp angulation between the second and third segments of coccyx, which was felt to be traumatic. A January 2010 bone scan showed mild increase in the area of the symphysis pubis. MRIs of the right and left hip from April and March 2011 were normal. A December 2009 MRI of the lumbosacral spine showed only some degenerative changes. An MRI of the pelvis was unremarkable as was an MRI of the cervical spine from April 2011. According to Dr. Birnbaum, the intermittent numbness in the hands could represent CTS. The pain in the pelvic area sounded musculoskeletal. He stated it was difficult to explain the intermittent numbness in the buttocks and perineal area on an organic basis. She had no objective clinical findings and nothing was noted on the MRI of the lumbosacral spine or pelvis. He noted the Appellant appeared quite anxious, which he stated could have a bearing on her symptoms. He stated he would repeat her nerve conduction studies.

[43] On March 29, 2012, Dr. Birnbaum reported on the outcome of EMG test results. He stated he was unable to make a definitive diagnosis of CTS and that the Appellant may benefit from a therapeutic trial of splinting if her symptoms were sufficiently troublesome.

[44] On April 17, 2012, Dr. Jerzewski reported on EMG and nerve conduction velocity findings given the Appellant's low back pain radiating to the anterior pelvis and down the back of right leg to heel since the MVA. The pain was noted to be worse staying in one position for too long. All nerve conduction studies were within normal limits. All examined muscles showed no evidence of electrical instability. There was no electrodiagnositic evidence for right lumbosacral radiculopathy or bilateral neuropathy. Dr. Jerzewski indicated he could not fully rule out left lumbosacral radiculopathy.

[45] A June 27, 2012 MRI of the head, taken on account of a clinical history of increasing headaches, numbness, multiple pains and polyneuropathy, revealed small nonspecific foci of increased signal. The periventricular white matter bilaterally were most likely microangiopathic.

[46] A July 27, 2012 MRI of the lumbar spine revealed mild degenerative changes, no significant compressive lesion to the central canal or neural foramina.

[47] A September 5, 2012 abdominal ultrasound, taken on account of right upper quadrant pain, revealed dominant fluid collection and/or cystic mass in the left upper quadrant. Exact etiology was uncertain. A pelvic and transvaginal ultrasound taken on account of pelvic pain revealed a small probable fibroid.

[48] On September 10, 2012, Dr. Gawel, neurologist, reported that the Appellant's MRI showed a minimal broad based bulge at L4-5 with mild facet hypertrophy causing mild canal narrowing. At L5-S1, there was a broad based bulge with moderate bilateral facet hypertrophy and mild bilateral foraminal narrowing. There was no significant compressive lesion to the central canal neural foramina. According to Dr. Gawel, the Appellant's symptoms were extremely severe, however she was complaining of pain in her vagina, going into her bladder and down her legs when she walked, suggestive of some compressive pathology for which Dr. Gawel stated he had no evidence. He recommended that the family doctor refer her to an orthopedic surgeon locally. As for her wrist problems, Dr. Gawel thought she had CTS and suggested she try wrist splints.

[49] A March 5, 2013 MRI of the sella revealed mild microangiopathic changes with no significant interval changes compared to previous examinations in July 2008 and February 2011.

[50] On April 3, 2013, Dr. Goguen saw the Appellant for her prior microprolactinoma. She noted the Appellant had a car accident which left her with diffuse pain. She was taking Lyrica, Seroquel and Tylenol No. 1. Her pituitary function appeared stable as did her small lesion on the left side of the pituitary. Dr. Goguen stated she would see the Appellant in one year's time.

[51] On April 30, 2013, Dr. Koczorowska, psychiatrist, wrote to the Respondent. She stated she was providing information which would allow the Respondent to reconsider its decision to deny the Appellant's CPP Disability application. She stated the Appellant was referred to her by Dr. Michalski due to depression/chronic pain syndrome. She first assessed the Appellant on April 4, 2013 and saw her in three follow up sessions on April 11, April 17 and April 30, 2013. The Appellant's chief complaint was the MVA. She could not function since then. She could not walk, sit or stand, had numbness in her back, twitching inside and pain in her pelvis, back, neck, arms and legs. She had extensive physiotherapy, massage therapy and acupuncture. According to Dr. Koczorowska, the Appellant's current symptoms were as follows:

> Affective: depressed mood and anhedonia. Cries a lot. Used to have suicidal idea about overdose.
>
> Cognitive: fluctuating feelings of worthlessness, some hopelessness and helplessness, feelings of guilt, problems with concentration and memory, indecisiveness.
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> Functional Inquiry: complaints of problems sleeping, waking up often, light sleep due to pain. Nightmares about the MVA (more frequent in past). Decrease in appetite (gained 10 k). Fatigue, loss of energy and no sex drive.
>
> Anxiety: Somatic: chest pains, sweating, trembling, shaking, SOB, feeling of smothering, feeling of choking, dry mouth, a lot of nausea, abdominal discomfort, dizziness, unsteadiness, numbness, tingling, muscle tension, hot flashes and chills.

Psychological: Worries a lot. Often irritable and feels on edge. Has fears of worst happening. Is afraid of left turn and of having MVA. Drives rarely. Has strong fear of developing multiple sclerosis in future.

Pain: suffers from tremendous amount of pain. Complains of pain in groin, pubic area, hip and buttock. It is intermittent and is increased by sitting or walking more than 10 minutes. It lasts for several hours. Complains of trouble with legs and climbing stairs, numbness in hands and legs, burning sensations in eyes, leg and sometimes entire body.

Current medications: Nortriptyline, Seroquel since Dec, Lyrical, Tylenol 3.

ADLs: does not do a lot at home. Husband helps. Does light cooking.

Relations: Does not go out due to pain.

Investigations: MRI brain 2012: periventricular white matter changes most likely microangiopathic; MRI brain 2013: pituitary lesion and microangiopathic changes; CT pelvis 2011: degenerative changes in region of symphysis pubis. Whole body scan 2010: mild uptake increase in area of symphysis pubis that represents diastasis pubis; MRI spine 2011: hemangiomas in vertebrae bodies T3 and T4. MRI spine 2009: degenerative disc disease L5-S1.

[52] Dr. Koczorowska diagnosed Major Depressive Disorder with Comorbid Anxiety, PTSD, Pain Disorder Associated with both General Medical Condition and Psychological Factors. Under Axis III she stated: “History of prolactinoma resection in 1990. History of chronic pain, headaches, bilateral carpal tunnel syndrome, GERD, rectal bleeding and constipation”. Under Axis IV she stated: “Stressors: MVA 2009. Has to deal with chronic pain. Demoralized by inability to work. Under AXIS V, she set out a GAF: 45-50. She stated she started seeing the Appellant in psychotherapy and for monitoring of her medication and would continue her on Nortripytline, Seroquel, Lyrica and Tylenol.

[53] In terms of the Respondent’s position to deny the application because medical information showed only mild degenerative changes in the lumbar spine and pelvic area with no indication that light work was contraindicated, Dr. Koczorowska stated that the Appellant has

severe pain that totally impairs function. She is not able to sit, walk or stand longer than 10-15 minutes. Dr. Koczorowska diagnosed Pain Disorder and stated: “It is well known that in this disorder the impairment is not correlated with the degree of the physical findings. Patients may develop excruciating pain even if they have minor changes on imaging. Of notice, the patient has changes in her symphysis pubis. It is extremely sensitive area for pain which is where most of her pain is located”.

[54] In terms of the Respondent’s assertion there is no indication the Appellant is regularly treated by a mental health professional as would be expected of someone with a severe psychiatric condition, Dr. Koczorowska stated that in her opinion, the Appellant had been adequately treated by her family physician. She indicated the waiting list to see psychiatrists is extremely long, that the Appellant’s English is poor and that there are few Polish speaking psychiatrists in the area. Under Opinion, Dr. Koczorowska stated:

> She is substantially disabled. She can only function at her own pace and in sheltered environment. Her symptoms are very severe. Her Activities of Daily Living are impaired. She will not recover in the foreseeable future; she may not even recover at all. Concomitant PTSD, anxiety, depression and pain are very poor prognostic factors. There is more psychosocial impairment, increased risk of suicide and slower recovery.
>
> Her prognosis is guarded. She has severe symptoms and prolonged condition. She will not recover in the foreseeable future.
>
> Based on the review of my chart, the review of the available documentation, course of her illness and her current presentation, it is my professional opinion that (the Appellant) did have a severe disability that was both severe and prolonged and that has been continuous since. Her presentation has been consistent with a continuous, severe disability that started in 2009 and has continued until present.
>
> I believe that she had condition that would preclude her from functioning consistently within her severe limitations in any work in 2009 and continuously onward.

[55] On October 23, 2013, Dr. Koczorowska sent a letter to the Tribunal. She stated that the Appellant continued to experience severe symptoms of depression, pain, anxiety and PTSD. There was also deterioration in her pain, especially in the lower back that impairs function. In terms of the Respondent's submission that not all treatment modalities had been attempted, Dr. Koczorowska stated the Appellant indicated she was treated for pain by her family doctor and had been tried on Lyrica, Nortriptyline, Tylenol 3 and Cymbalta. She was unable to attend any pain programs as she was completely incapacitated by her symptoms and needed to be accompanied to all appointments by her spouse. She was further not able to attend any regular activities which would result in her spouse being absent from work. Dr. Koczorowska stated that, to her knowledge, the family physician had referred the Appellant to the pain clinic, however the Appellant was looking for another option since the pain clinic was too far from her residence.

[56] Dr. Koczorowska also responded to the Respondent's assertion that no physician had indicated that the Appellant required a polish speaking psychiatrist. She stated she believed the Appellant required a polish speaking psychiatrist given the special relationship between psychiatric/patient which requires both privacy and confidentiality.

[57] In terms of the Respondent's position that Dr. Koczorowska exceeded the scope of her expertise by stating the Appellant could not work due to chronic pain, Dr. Koczorowska stated that psychiatric chronic pain/pain disorder is a psychiatric diagnosis included in DSM IV and V.

[58] In terms of the Respondent's position that Dr. Koczorowska did not assess the Appellant and diagnose major depression and PTSD until April 2013, that no other physician diagnosed major depression and that the Appellant did not require any hospitalizations for a major mental illness, Dr. Koczorowska stated the Appellant did not have access to a psychiatrist until she saw the Appellant in April 2013. However, her symptoms started right after the 2009 MVA. They were managed by the family doctor. In her opinion, the focus of assessment and management of the other physicians was mainly pain. She stated: "It is well known that pain can be a sign of Somatization Syndrome and some patients are unable to verbalize their distress and they are using the pain as a way to express their psychological turmoil". She explained that some patients with PTSD relieve their trauma thought pain, which often masks the underlying issues of depression. Because the patient has such strong pain, "classical symptoms" of depression can be easily missed.

[59] Dr. Koczorowska also addressed the Respondent's position that chronic pain in the absence of a pathological medical condition does not preclude all types of activity including suitable work and that the pain specialist noted the pain was only intermittent. She stated that one does not need to have a pathological medical condition in order to diagnose chronic pain. Also, the severity of pain does not depend on the nature of the pain. She also quoted from an October 20, 2010 report of Dr. Cheng, physiatrist, as follows: "Pain disorder only with psychological factors can totally impair patient's functioning. I do not believe that this is the case with (the Appellant) and there was some suggestion in previous reports that she may be (sic) previous instability of symphysis pubic that may be a cause of her pain. The further diagnostic and medical clarity needs to be provided with regards to (the Appellant's) MVA-related pelvic injury". Dr. Koczorowska noted Dr. Cheng's suggestion that the Appellant be referred to an orthopedic surgeon or pain specialist with expertise in pelvic pain disorders.

[60] Finally, in terms of the Respondent's position that under the CPP, it considers a person's capacity for all types of work, full-time, part-time, casual or seasonal and that no physician indicated the Appellant was incapable of suitable work, Dr. Koczorowska responded as follows: "I would like to reiterate that patient is totally disabled. Based on the review of my chart, the review of the available documentation, course of her illness and her current presentation, it is my professional opinion that (the Appellant) did have a severe disability that was both severe and prolonged and that has been continuous until present. I believe that she had condition that would preclude her from functioning consistently within her severe limitations in 2009 and continuously onward. She will not recover in the foreseeable future.

[61] On October 23, 2013, the Appellant was diagnosed with gallbladder, cholecystectomy, mild chronic cholecystitis and cholesterolosis. No gallstones were identified.

[62] On November 4, 2013, Dr. Michalski wrote to the Respondent. He stated the Appellant was under his care since 1990. Her health had deteriorated following the 2009 MVA. She developed Major Depression, PTSS and Chronic Pain Syndrome. In spite of intensive physiotherapy, psychotherapy and pharmacological treatments, her condition has deteriorated further. She had multiple trials with many anti-psychotic and anti-depressant medication without visible improvement. Since 2009, she has been followed almost weekly and had seen many

consultants including the Pain Clinic. Dr. Michalski stated he believed the Appellant's main problem is PTSS and chronic depression. The Chronic Pain syndrome is caused by Fibromyalgia. On physical examination, she has exquisite tenderness on typical trigger points. The pain includes the pelvic area, legs, gluteal areas, shoulders, elbows, wrist and occipital area. She is unable to stand, sit or walk more than 15 minutes. Her spouse performs all household chores. Her activities of daily living are severely restricted. After 4 years of intense therapy, her mental and physical condition will not change. She is awaiting a consultation with Toronto Touch clinic, which specializes in treatment of fibromyalgia.

[63] On November 21, 2013, Dr. Smith reported that the Appellant was seen in follow up to laparoscopic cholecystectomy. She was doing well. The pathology showed cholesterolosis but no gallstones. Dr. Smith stated that hopefully, the surgery would help with her chronic abdominal pain.

[64] On March 15, 2014, Dr. Doidge, Toronto Touch Clinic, reported on his January 2013 and February 2014 assessment of the Appellant. He reported that her chief complaints were of right shoulder pain, lower back pain and buttock and groin pain on both sides. She further described swelling of her legs and ankles. According to Dr. Doidge, the Appellant's total Fibromyalgia Impact Questionnaire score was 94.1 out of 100, which, he explained, was an "extreme" form of fibromyalgia. He stated she met the clinical diagnostic criteria for fibromyalgia and had 18/18 tender points. He recommended she undertake cognitive behavioural therapy for sleep and encouraged supportive psychotherapy. He concluded by stating: "She qualifies as having post- traumatic fibromyalgia. Her multitude of symptoms makes it impossible for her to work at this time".

[65] On April 9, 2014, Dr. Goguen reported he saw the Appellant for follow up of her microprolactinoma. She had been amenorrheic since 2011 and denied any galactorrhea. She sometimes had dizziness but it was not associated with any syncope, presyncope or loss of consciousness. Dr. Goguen indicated the Appellant's pituitary function appeared stable both on clinical and laboratory investigations.

[66] A November 27, 2014 right shoulder ultrasound revealed partial thickness tear of the subscapularis and supraspinatus tendons.

[67] A December 17, 2014 left shoulder ultrasound revealed partial thickness tear of the supraspinatus tendon.

[68] A December 17, 2014 thyroid ultra sound revealed a few thyroid nodules.

[69] On January 14, 2015, Dr. Koczorowska, psychiatrist, reported that the Appellant's health had deteriorated with chronic pain. She had more pain in her in back, left leg and right arm. The Appellant stated that she suffered from total body pain. She discovered that she had rotator cuff tears, partial tear of the subscapularis and supraspinatus tendons. She continued to have pain in her pelvis. She hardly moved, did not go out and could not do anything at home. Dr. Koczorowska stated: "Based on my assessments (the Appellant) physical and mental impairments disabled her from working at any occupation. I believe that patient's symptoms are severe. Patient suffers from severe functional limitations, impairments and restrictions with respect to her activities of daily living, ability to function in the workplace and ability to function in the community. I believe that he (sic) is resistant to treatment and he (sic) is not going to recover in the foreseeable future".

[70] On January 31, 2015, T. Blaszcyk, registered physiotherapist, reported that the Appellant receives physiotherapy and massage therapy treatments due to her injuries.

[71] On February 4, 2015, L Wojciechewicz, osteopath, RMT, reported that the Appellant attended since September 5, 2012 for pain in the low back and symphysis pubis area. She presented with high sensitivity, high irritability, stress and inability to relax due to pain. She had no improvement after treatments. Walking was very painful. She could not do exercises due to complaints of pain. She was discharged due to lack of improvement.

[72] A March 6, 2014 bilateral knee x-ray revealed normal bilateral knee radiographs.

[73] A March 16, 2015 MRI Sella GAD was compared to a March 5, 2013 report. There was no interval change in the size and configuration of a left-sided pituitary lesion. It had stable appearance in comparison to the previous examination.

[74] A June 15, 2015 pelvis and hips imaging report revealed mild enthesopathy involving the left greater trochanter. The same day, a pelvis and bilateral hips radiology report indicated a

negative examination. A bilateral hip ultrasound revealed mild enthesopathy involving the left greater trochanter.

[75] On July 2, 2015, the Appellant was evaluated for her chronic abdominal pain and consideration of gastroscopy and colonoscopy. She was described as a woman with chronic pain, fibromyalgia and depression. The assessor doubted there was anything significant going on in the GI tract. She underwent gastroscopy and colonoscopy. Her preoperative diagnosis was chronic abdominal pain. The postoperative diagnosis was hiatus hernia, normal colonoscopy to terminal ileum.

[76] On July 13, 2015, Dr. Mendelsohn, saw the Appellant for otalgia, which appeared to be TMJ related. He recommended dental follow up. He noted her pharyngitis may be related to laryngeal reflux disease or could be rhino pharyngitis related to postnasal drip. He recommended a sinus rinse.

[77] On August 6, 2015, Dr. Aboodi, DMD, reported on his assessment of the Appellant for joint pain in the right TMJ. He noted she attends physiotherapy every 2 weeks for fibromyalgia. Her TMJ pain started prior to her MVA six years earlier and became worse after the MVA. The TMJ pain increases during the day. The Appellant reported sleeping 8-10 hours yet still feeling tired. She saw an ENT and there were no significant findings. On examination, Dr. Aboodi diagnosed myofascial pain due to fibromyalgia. He stated that pain on palpation from the rear did not seem to originate from TMJ and recommended further ENT investigation. He recommended physiotherapy for TMJ and assessment for sleep apnea.

[78] On September 2, 2015, Dr. Springer reported he saw the Appellant for follow up of her gastroscopy and colonoscopy for chronic abdominal discomfort. The gastroscopy showed a small hiatus hernia. According to Dr. Springer, the Appellant’s symptoms were more functional in nature. He recommended a FODMAP diet and repeat colonoscopy in 10 years’ time.

[79] A September 8, 2015 bilateral knee ultrasound revealed minimal calcification at the quadriceps tendon insertion of the quadriceps insertion onto the patella. The impression was one of minimal enthesopathy.

Oral Testimony

[80] She is originally from Poland. She came to Canada in 1988. She was age 28 or 29. She completed high school in Poland which she believes would be the equivalent of Grade 12 in Ontario today. Between 1979 and 1988, she worked full-time in Poland in an office as a human resources specialist. She would search for employees and prepare contracts. She did not study English at school in Poland.

[81] When she came to Canada, she could not speak English. She was enrolled in an ESL course for several months.

[82] Currently, she can speak, read and write English with difficulty.

[83] After she came to Canada, between 1992 and 2006, she first worked in a Polish Deli as a cashier/counter clerk. She did not work between 1988 and 1992. Between 1997 and 2006, she worked in another Polish Deli again as a cashier/counter clerk. In both jobs, she tried to serve her customers in English. She needed basic English to get by in both jobs. She left the second Deli job after the store closed and went on Employment Insurance. She then worked at Polcan Meat and Deli between September 2008 and September 2009. She did the same kind of job, i.e., counter help/cashier. She left the job following the MVA.

[84] During the MVA, she was sitting in the back right seat of the car as a passenger. The car was struck by the other vehicle in the location where she was seated. She suffered injuries to her pelvic region, legs and lower body. After the MVA, she never tried to return to Polcan Deli. She was in so much pain she could not do it. She did not work at any other place. She tried to find some lighter jobs but nobody wanted to hire her.

[85] After she stopped working at Polcan Meat and Deli, she worked for her spouse in 2011, 2012 and 2013 during which period of time she earned $11,500.00, $8,342.00 and $8,544.00 respectively.

[86] In 2011, she started working for her spouse doing timesheets for his business. Her spouse is a subcontractor who installs insulation for pipes in buildings. She did the timesheets manually using pen and paper. He provided her the work for her mental health, to give her some money of

her own and to give her something to do. She suffered from pain and needed something to distract her. She accepted his proposal as she wanted to have something to do. She performed the work when she was able to do it and when her pain was not too strong. She worked throughout all of 2011. She worked from home. To the best of her recollection, her earned income in 2011 was based on her working one day a week on average. She worked on average between one to two hours on the days she worked. She would work for about fifteen minutes and then take a break. It was hard to perform the work as she suffers from carpal tunnel syndrome, has pain in her fingers, back and pelvis and has difficulty sitting. She would not have been able to perform the work for the whole day or one to two hours every day of the week. She has too much pain in her back and has difficulty sitting. After working for one to two hours, she would feel pain and exhaustion. She could not have worked beyond two hours.

[87] She earned $8,342.00 in 2012 and $8,544.00 in 2013. She performed the same work for her spouse but decreased her time worked. There were weeks she could not work at all. She might work every second week or even less depending on how she felt. At times, she was in so much pain she could not leave the house. When she did work, it was for approximately 45 minutes or an hour. She stopped working for her spouse at some point in 2013 but could not be specific as to when this was. She has not worked for him since then. She stopped working because she was in too much pain, had a problem with concentration and was making too many mistakes.

[88] She still drives occasionally for short distances. She may drive up to 3-4 times per week for a short distance when she feels less pain. If she feels worse, she does not leave the house. She may drive to the doctor, physiotherapy, the osteopath and for massage. The longest period she drives is up to 20 minutes to attend treatment for her pelvic pain. At times, she drives to the subway, parks the car and takes the subway which permits her to rest. The long trip to see her doctor is once every two weeks. She drives while in pain.

[89] She recalls attending the Rothbart Pain Centre on one occasion in 2010. She recalls that needle injections (nerve blocks to the neck and hip) were recommended. She was afraid to undergo needle injection and was concerned the result might be worse than before. She did not have them. She cannot recall if she discussed her fear with Dr. James at the Rothbart Centre or her family doctor. She recalls trying Indomethacin for her headaches which did not help. She

cannot recall if she was prescribed Topamax. She was scared to return to Rothbart given her fear of having needles.

[90] She currently takes Lyrica75 mg twice daily; Cymbalta 120 mg once daily; Clonazepam 1.5 mg 1x daily; Pantaloc 40 mg one to two times daily; Tylenol 3 2x daily; Ranitidine 150 mg once daily; Nospa 80 mg two times daily; Diclofenac 1.5 % 3x day (drops); Kofex DM 3x day two teaspoons; Vitamin B12; Resotran 2 mg once daily; Locacorten Vioform 2 drops 3x daily; (1.48); and medications to help with liver function. She does not experience any side effects from her medications.

[91] She currently sees the family doctor once a week or once every two weeks. She sees an endocrinologist and her psychiatrist, Dr. Koczorowska once monthly. They discuss how she is feeling.

[92] She last had physiotherapy approximately one or two months ago at which time her spouse's health insurance benefits expired. She can no longer afford to attend therapy.

[93] She lives in a townhouse with her spouse.

[94] She can shower/bathe herself. She has difficulty getting into the bathtub and occasionally asks her spouse to be close by.

[95] She can dress herself but sits to put on her shoes. Her spouse helps her to put on her jacket or winter coat because she feels strong pain in her shoulder blade.

[96] Her spouse does the housework. She occasionally tries to do light meals but takes a long time and requires rest. She goes with her spouse to do the grocery shopping. She cannot lift heavy items. He does the laundry.

[97] During a typical day, she does exercises to ameliorate her condition and watches television. She socializes on a limited basis.

[98] She has problems sleeping. She often wakes up or goes to sleep at 3:00 am or 4:00 am because she cannot fall asleep due to pain. She wakes up feeling unrested and in pain.

[99] She cannot predict her pain from day to day.

[100] She has fibromyalgia. Her pain is increasing more and more.

[101] She drove a short distance (5-6 kilometers) slowly to her paralegal's office to participate in the teleconference.

[102] She has not done any volunteer work since she last worked in the Deli or worked elsewhere, apart from the work she performed for her spouse out of her home.

[103] Since she last worked in the Deli, there is no job she thinks she could perform. She is in constant pain and occasionally cannot even leave the house.

[104] She called several employers in 2014 or 2015 about working in deli type jobs. She explained she has restrictions involving limited standing, sitting and requires breaks to walk off the pain in her lower back. No one called her back to hire her.

[105] She has limited knowledge how to use a computer.

SUBMISSIONS

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

a) Since the MVA, her condition has affected her significantly. Her health condition has deteriorated gradually since the MVA. She is suffering from PTSD, fibromyalgia, chronic lumbar pain and chronic pain syndrome. She lives day and night with pain. It affects her ability to sleep. In April 2013, she started seeking medical assistance from a psychiatrist. She is on pain killers and takes antidepressant medication. Her health conditions, including lack of concentration, affect her ability to engage in any employment, even part-time.

b) The medical reports clearly show her conditions are severe and prolonged as defined in the CPP.

c) She should start to receive CPP disability benefits as of January 1, 2014 given her previous work for her spouse, subject to the Tribunal's determination of an earlier date of onset.

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

a) She was last employed as a salesperson between September 2008 and September 2009 when she stopped working due to an MVA. She indicated she felt she could no longer work as of September 2009. She has self-employed earnings after she stopped working in the years 2011 ($11,500.00), 2012 ($8,342.00) and 2013 ($8,544.00). These earnings extended the previous MQP of December 2011 to December 2014. The nature and the source of these self-employed earnings were not disclosed.

b) Dr. Cheng, physiatrist, reported in his October 2010 Independent Medical Assessment that she had diastasis of the symphysis pubis but recommended referral to an orthopedic surgeon or pain specialist. He noted her musculoskeletal injuries had resolved and her headaches were largely resolving. He opined that prognosis for full recovery of her soft tissue injuries was excellent given her unremarkable musculoskeletal findings. He did not find any neurological impairment. This does not support a severe pathology or impairment precluding all types of work.

c) Dr. Doidge, Toronto Touch Clinic (no specialist designation noted with College Physicians and Surgeons of Ontario) stated in his March 2014 report that the Appellant presented with post-traumatic fibromyalgia for which conservative measures were suggested, e.g., exercise, sleep hygiene, self-help books. A diagnosis of fibromyalgia does not necessarily preclude all work, particularly part-time or modified work.

d) Dr. Birnbaum, neurology, in his February 1, 2012 report stated he saw the Appellant for pain in her groin, pubic area, hip and buttock. He indicated the pain was intermittent. He felt the intermittent numbness in her hands could represent carpal tunnel syndrome and that her pelvic area pain was musculoskeletal. His review of investigations did not reveal

a severe pathology. He concluded she had no objective clinical findings and that nothing was noted on the MRI of the lumbosacral spine or pelvis. He observed she was quite anxious, which he opined could have a bearing on her symptoms.

e) On September 10, 2012, Dr. Gawel, neurologist, reported he found no evidence of any compressive pathology in her spine and suggested that she be referred to an orthopedic surgeon. He recommended she wear wrist splints for her wrist problems.

f) Dr. Koczorowska, psychiatrist, reported she first assessed the Appellant in April 2013. She diagnosed major depressive disorder with comorbid anxiety, PTSD and pain disorder. On October 23, 2013, she reported that the Appellant still had symptoms of depression, pain, anxiety and PTSD as well as pain in her back. She stated the Appellant was treated by her physician for her pain symptoms and did not attend any pain programs. She noted the Appellant did not see a psychiatrist until April 2013 and stated her symptoms had been managed by the family doctor until then. While of the opinion that the Appellant was not able to work in any capacity, Dr. Koczorowska did not provide a list of medications or her clinical notes or observations. There is no indication the Appellant required any aggressive psychiatric interventions.

g) The medical evidence supports capacity for work. She had self-employed earnings after she stopped working in 2011, 2012 and 2013. There is no indication she required aggressive medical interventions. She has not established a severe and prolonged disability as of December 2014.

h) On September 10, 2012, Dr. Gawel, neurologist, found no evidence of compressive pathology in the spine. He recommended she wear wrist splints for her wrist problems.

i) While Dr. Koczorowska states in her January 14, 2015 report that she believes the Appellant's conditions are severe, she did not provide mental status examination findings and there is no indication of aggressive treatment measures for either the Appellant's mental health or pain conditions. While Dr. Koczorowska's opinion is acknowledged, it is difficult to reach a finding of disability.

j) New medical documents reveal she was seen and treated for post-nasal drip, has been diagnosed with a hiatus hernia (dietary change was recommended) and was assessed by a periodontist (no severe conditions were revealed). A physiotherapy note identifies she was treated for pain symptoms. Radiographic evidence did not reveal any severe underlying pathologies. While limitations may be present related to her ongoing symptoms, the presence of a severe condition precluding all work was not identified.

k) While acknowledging the longstanding nature of her pituitary condition, this condition is stable. She is monitored by her endocrinologist yearly and has not required medical management since 2007. She undergoes regular investigations and is monitored for longstanding bilateral breast cysts. The evidence suggests this condition is benign as no severe pathology or impairment has been identified. She has worked with these conditions.

l) She is followed intermittently by gastroenterology with the most recent consult report dated September 2, 2015. The specialist noted the investigations revealed the presence of a small hiatus hernia and biopsies of the stomach and esophagus were normal. The colonoscopy was normal and the specialist suggested dietary changes to manage her symptoms. The additional evidence does not support the presence of severe pathology which would preclude all work activity as of December 31, 2014 and continuously thereafter.

m) It is the capacity to work and not the diagnosis or disease description that determines the severity of the disability. Although her multiple medical conditions are longstanding in nature, the medical evidence indicates her conditions are stable and managed conservatively by various specialists. She has worked with these conditions in the past. She had self-employed earnings reported on her record of earnings in 2011, 2012 and 2013, which is after she stopped working in September 2009.

ANALYSIS

[108] The Appellant must prove on a balance of probabilities that she had a severe and prolonged disability on or before December 31, 2014.

Severe

[109] The Tribunal is satisfied that the Appellant has suffered chronic unremitting pain since the September 2009 MVA in her groin radiating to her bilateral buttock, hip and thigh. The pain is made worse with prolonged sitting, standing, and walking. As noted by Dr. James, Rothbart Centre for Pain Care Ltd, in his July 22, 2010 report, he saw the Appellant for groin pain which she had for nine months resulting from the MVA. On the VAS scale, it was rated at 7/10 and radiated to the bilateral buttock, hip and right high. It was made worse by prolonged sitting, standing and walking.

[110] The Appellant also has neck pain which dates back to the MVA. Again, Dr. James described it in his July 22, 2010 report as dating back to the MVA. It was also rated at 7/10 on the VAS pain scale and was described as radiating to the occiput and temporal lobe and made worse by night-time sleep. On examination, although she had full cervical range of motion, she had reduced lumbar flexion, extension and flexion. Dr. James provides a series of diagnostic impressions as previously described.

[111] The Tribunal is more concerned with limitations in function than diagnosis. Significantly, Dr. James took the Appellants' pain significantly, did not question that her pain was made worse by prolonged sitting, standing or walking and recommended both medication and a trial of nerve blocks.

[112] According to the Appellant she tried Indomethacin without success. She cannot recall if she was prescribed Topamax. Although she did not pursue nerve block injections, she testified that she was afraid and concerned that treatment might worsen her condition.

[113] Although an applicant is generally obliged to show a conscious effort to seek relief from a pain management facility, the treatment of which may be effective in allowing the person to engage in gainful work, the Tribunal is also mindful of the ratio in *Bulger v. MHRD* (May 18, 2000) CP 9164 that compliance must be viewed in the context of an applicant's circumstances and that persons afflicted with fibromyalgia and experiencing constant diffuse pain, lack of proper sleep, loss of energy, feelings of despair and associated depression, cannot be expected to

engage in treatment programs with the same enthusiasm and positive attitudes as persons recovering from fracture or a traumatic injury. Given the Appellant's diagnosis of fibromyalgia and chronic pain, her constant diffuse pain, lack of sleep, loss of energy, PTSD, anxiety and depression and feelings of hopelessness and helplessness, the Tribunal is satisfied the Appellant's unwillingness to pursue nerve block injections resulting from her fear of treatment and getting worse, should not disentitle *per se* given the above factors, to consideration of a CPP Disability pension.

[114] The Tribunal also notes that, on balance, the Appellant has been compliant with medical treatment, had attempted various modalities of treatment, has seen numerous specialists and continues to receive psychiatric treatment. She only recently stopped receiving physiotherapy after her spouse's health insurance benefits expired.

[115] On balance, the Tribunal is satisfied the Appellant has been compliant with her physicians' treatment recommendations.

[116] Dr. Birnbaum stated the Appellant's pain in the pelvic area sounded musculoskeletal although he could not explain intermittent numbness in the buttocks and perineal area on an organic basis. According to Dr. Birnbaum, the Appellant had no objective clinical findings and nothing was noted on the MRI of the lumbar spine or pelvis.

[117] Similarly, Dr. Jerzewski reported that all nerve condition studies were within normal limits, all examined muscles showed no evidence of electrical instability and there was no electro diagnostic evidence of right lumbosacral radiculopathy or bilateral neuropathy. He did indicate, however, that he could not fully rule out left lumbosacral radiculopathy.

[118] Dr. Gawel, neurologist, was unable to find evidence of compressive pathology which might explain some of the Appellant's symptoms.

[119] However, Dr. Cheng, physiatrist, who completed a Physiatrist Independent Medical Examination of the Appellant in October 2010, noted the Appellant continued to exhibit objective musculoskeletal impairment arising from the MVA and stated that the following diagnostic considerations applied: i) diastasis of the symphysis pubis; ii) musculo ligamentous strain/sprain of the cervical and lumbosacral spine (which he felt to have been resolved); iii)

likely strain and/or contusive injury to the distal aspects of the upper limbs and left leg and ankle (which he felt to have been resolved); and iv) post traumatic headaches (which he felt to be largely resolving). He also supported a diagnosis of post-traumatic headache and residual elbow pain.

[120] The Tribunal is satisfied that the medical record provides some objective evidence to account for the Appellant's significant and functionally disabling pelvic pain based on Dr. Cheng's findings.

[121] In any event, even absent objective evidence, the Tribunal notes that Drs. Birnbaum, Jerzewski and Gawel did not question the genuineness of the Appellant's complaints, although Dr. Birnbaum noted she appeared "quite anxious", which he stated could have a bearing on her symptoms.

[122] The Tribunal has also considered the fact that different physicians have provided different diagnoses to explain the Appellant's symptoms.

[123] For example, in April 2013, Dr. Koczorowska, psychiatrist, diagnosed not only Major Depressive Disorder with Comorbid Anxiety, PTSD, but also Pain Disorder Associated with both General Medical Condition and Psychological Factors. She explained that a diagnosis of Pain Disorder is not correlated with the degree of physical findings, noting that patients may develop excruciating pain even if they have minor changes in imaging. In that regard, she indicated that the Appellant had changes in her symphysis pubis, which is an extremely sensitive area for pain. Based on her review of the chart, review of available documentation, course of illness and current presentation, it was her professional option that the Appellant had a severe disability that was both severe and prolonged and continuous that started in 2009 with the MVA.

[124] In a March 15, 2014 report, Dr. Doidge, Toronto Touch Clinic, diagnosed fibromyalgia and described 18/18 tender points.

[125] Whatever the formal diagnosis, the Tribunal is satisfied that the common denominator underlying the medical record is chronic unremitting pain which affects the Appellant's capacity to engage in prolonged walking, standing and sitting.

[126] Based on her MVA related injuries, Dr. Cheng anticipated that the Appellant would be unable to tolerate prolonged walking, sitting to standing transfers and heavy lifting and carrying. He further indicated she would have difficulty tolerating her requisite job duties involving prolonged standing, walking, bending and lifting/carrying as a result of her impairment and that she was substantially unable to perform her pre-accident employment tasks as a salesperson/clerk at a X deli.

[127] Given the Appellant's difficulties with ambulation, standing, and heavy lifting and carrying, the Tribunal is satisfied the Appellant would not be able to perform her previous deli job or any physical work.

[128] Although Dr. Cheng did not describe any limitations involving prolonged sitting in his October 2010 report, Dr. James did so in his July 2010 report in which he appeared to accept without objection or comment the Appellant's description of bilateral buttock, hip and right thigh pain made worse by prolonged sitting, standing and walking. Also, in his February 2012 report, Dr. Birnbaum reported that the Appellant complained of pain in the groin, pubic area and hip as well as buttock, He noted it occurs primarily when sitting. Although he stated the pain was intermittent, which fact the Respondent has noted, he also stated she has it on a daily basis and that it may last up to several hours (GD3-38). In her April 2013 report, Dr. Koczorowska indicated the Appellant was unable to sit, walk or stand longer than 10-15 minutes. In his November 2013 report, Dr. Michalski, family physician, also noted the Appellant was unable to stand, sit or walk greater than 15 minutes.

[129] Given her restrictions involving prolonged sitting, poor sleep and the cognitive problems identified by Dr. Koczorowska, the Tribunal is further satisfied the Appellant does not possess residual capacity to perform light sedentary work or retraining.

[130] The Tribunal has considered the fact of the Appellant's work for her spouse in 2011, 2012 and 2013. Although her earnings are indicative of some capacity to work, given the Appellant's unchallenged and credible explanation as to the limited and infrequent hours worked from home where she would work for fifteen minute increments and take a break, the Tribunal is not satisfied the work she performed evidenced capacity regularly on her part to pursue a substantially gainful occupation in the competitive labour market. Rather, her limited capacity to

work for fifteen minutes before she required a break supports a finding to the contrary. She was capable at most of working one day a week in 2011 and up to one to two hours. She would work for approximately 15 minutes and then take a break due to her pain and functional restrictions. She reduced the frequency and hours worked in 2012 and 2013.

[131] Given the Appellant's explanation that her spouse proposed the job in order to give her something to do, the limited nature of the work performed and the accommodations she received, the Tribunal finds that the Appellant was effectively working for a benevolent employer; her work was not reflective of what would be reasonably required of her in the competitive workplace.

[132] Although the Appellant remains capable of driving short distances, the Tribunal does not find that this translates into a capacity regularly to pursue any substantially gainful occupation in the competitive workplace.

[133] The Tribunal is satisfied, on balance, that the Appellant has suffered from a severe disability as defined in the CPP commencing in September 2009 resulting from the MVA, which has resulted in significant pain and functional restrictions affecting prolonged sitting, walking and standing.

[134] Also, given the mental/psychological impairment identified by Dr. Koczorowska in 2013, i.e., depression, pain, anxiety and PTSD, and her professional opinion based on her review of the Appellant's chart, the available documentation, course of illness and current presentation, that the Appellant had a severe disability that started in 2009, the Tribunal is further satisfied the Appellant would not be a suitable candidate for retraining or light work. As previously noted, Dr. Koczorowska identified problems with sleep, fatigue, loss of energy, feelings of worthlessness, and problems with concentration and memory. These factors all militate against the Appellant being able to perform any substantially gainful occupation in the competitive workplace or to pursue retraining for lighter work.

Prolonged

[135] The Tribunal is satisfied the Appellant's disability is prolonged. Despite ongoing investigations and treatment since the MVA in 2010, she continues to suffer from ongoing pain and functional restrictions.

[136] As noted by Dr. Koczorowska in April 2013, the Appellant continues to suffer from severe pain that totally impairs function. She is unable to sit, walk or stand longer than 10-15 minutes. She stated the Appellant could only function at her own pace and that her activities of daily living were impaired. She opined that the Appellant would not recover in the foreseeable future and may not even recover at all.

[137] In his November 2013 report, Dr. Michalski stated that despite intensive physiotherapy, psychotherapy and pharmacological treatment, the Appellant's condition had deteriorated further. She was unable to stand, sit or walk more than 15 minutes. Her spouse performs all household chores and her activities of daily living are severely restricted. Dr. Michalski wrote: "After 4 years of intense therapy, her mental and physical conditions will not change".

CONCLUSION

[138] The Tribunal finds that the Appellant had a severe and prolonged disability as of September 2009 at the time of the MVA. For payment purposes, a person cannot be deemed disabled more than fifteen months before the Respondent received the application for a disability pension (paragraph 42(2)(b) CPP). The application was received in October 2012; therefore, the Appellant is deemed disabled in July 2011. According to section 69 of the CPP, payments start four months after the date of disability. Payments will start as of November 2011.

[139] The appeal is allowed.

Jeffrey Steinberg
Member, General Division - Income Security