Social Security Tribunal of Canada | Tribunal de la sécurité sociale du Canada

Citation: *A. B. v. Minister of Employment and Social Development*, 2017 SSTGDIS 30

Tribunal File Number: GP-15-3640

BETWEEN:

A. B.

Appellant

and

Minister of Employment and Social Development

Respondent

SOCIAL SECURITY TRIBUNAL DECISION

General Division – Income Security Section

DECISION BY: Carol Wilton

HEARD ON: March 9, 2017

DATE OF DECISION: March 14, 2017

Canada

REASONS AND DECISION

PERSONS IN ATTENDANCE

Appellant:	A. B.
Appellant's representative:	Caitlin Galvao
Intepreter (Hindi):	Harinderjeet Goel
Support person:	B. B. (Appellant's husband)

INTRODUCTION

[1] The Appellant's application for a *Canada Pension Plan* (CPP) disability pension was date stamped by the Respondent on December 5, 2014. The Respondent denied the application initially and upon reconsideration. The Appellant appealed the reconsideration decision to the Social Security Tribunal (Tribunal) on October 26, 2015.

[2] The Appellant was 51 years old in December 2016, the date of the minimum qualifying period. She has a Grade 10 education, and worked for some 28 years, most recently as an assembler in a factory. She was injured in a workplace accident in June 2008, subsequently undergoing rehabilitation while working on modified duties. She left work on October 25, 2013 because her employer did not have a modified job for her. Her main medical conditions were chronic pain in her shoulders and knee, low back pain, depression, panic, and anxiety (GD2-100).

[3] The hearing of this appeal was by personal appearance for the following reasons:

- More than one party will attend the hearing.
- The method of proceeding is most appropriate to allow for multiple participants.
- The issues under appeal are complex.
- 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

[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, 2016.

[8] In this case, the Tribunal must decide if it is more likely than not that the Appellant had a severe and prolonged disability by the minimum qualifying period.

EVIDENCE

[9] An X-ray of the lumbar spine dated September 3, 2008, showed moderate degenerative changes in the discs and posterior elements at L5-S1. Shoulder X-rays of the same date showed normal findings (GD2-115).

[10] On December 2, 2008, a bilateral shoulder ultrasound showed no full thickness rotator cuff tear. However, there was a marked severe left supraspinatus calcific tendinopathy, and mild to moderate diffuse right supraspinatus tendinopathy with some more severe tendinosis (GD2- 112). An MRI of the cervical spine dated January 20, 2009, showed some degenerative disc disease but no prominent focal disc herniation (GD2-116).

[11] Dr. Sangeeta Bajaj, a rheumatologist, saw the Appellant on April 20, 2009. She diagnosed the patient with chronic fibromyalgia and possible tendinitis of the left shoulder. Dr. Bajaj recommended that the Appellant take Amitriptyline or Lyrica for fibromyalgia. She was reluctant to have Cortisone injections in her left shoulder, and Dr. Bajaj conceded that this treatment might not be helpful in view of the fibromyalgia. She reported that the Appellant complained of poor sleep and chronic fatigue (GD2-108-109). Dr. Bajaj saw the Appellant again on November 5, 2009, and gave her an injection of Depo Medrol in her shoulder (GD2-117).

[12] On December 4, 2009, Dr. Mark Cohen of a pain management centre wrote the Appellant's family physician about a consultation for persistent neck and shoulder pain. The Appellant complained of severe headaches two or three times a week. She had injured her neck, shoulders, and upper back at work in June 2008. In spite of anti-inflammatories and pain medications, as well as physiotherapy and massage therapy, the pain persisted and in fact spread. The Appellant now had continuous pain only partly relieved by Tylenol #2 and Advil. Cortisone injections the month before had brought only minimal improvement. The diagnosis was severe left rotator cuff tendinopathy, mild cervical facet joint irritation, and chronic pain syndrome. Dr. Cohen made some recommendations regarding medication changes, physiotherapy, and the possibility of nerve blocks (GD2-44-48).

[13] The Appellant had nerve blocks with Dr. Cohen on March 12, 2010, and found them quite helpful (GD2-125).

[14] The Appellant had an assessment for the Workplace Safety and Insurance Board (WSIB) Functional Restoration Program (FTP) on September 28, 2010. She complained of left shoulder pain and neck pain radiating down through to her lumbar region. On examination, she had a decreased range of motion in the left shoulder and elbow, and cervical and lumbar spine.

A neurological exam showed weakness throughout the left arm and leg. She reported that she had been on Amitriptyline for sleep, but it contributed to memory loss. The intensity of her psychological symptoms was in the range of mild to moderate. The assessment team found no reason why she could not participate in the FRP, and the goal was that she return to work. She began treatment on October 8, 2010, and completed the program on February 4, 2011 (GD2-123 ff.).

[15] X-rays and ultrasounds of the left shoulder dated December 18, 2010, showed mild to moderate degenerative changes of the left acromioclavicular joint and a possible rotator cuff tendinopathy. There was a high grade partial tear of the left supraspinatus tendon (GD2-150).

[16] An MRI of the Appellant's left knee dated January 14, 2011, showed mild osteoarthritis, and a high signal within the medial meniscus, probably degenerative (GD2-151).

[17] The FRP discharge report, dated February 4, 2011, noted that a recent MRI of the left shoulder showed a full thickness tear in the left rotator cuff. Amended precautions were added to the Appellant's list of restrictions. The left shoulder was causing significant pain and interfering with her ability to carry out her job duties and activities of daily living. At the time of discharge, the Appellant could perform activities within the sedentary physical demand level (GD2-157-170). On February 11, 2011, the FRP Work Abilities Report #3 advised temporary functional precautions for the left shoulder, neck and upper back (GD2-154).

[18] The Appellant was assessed on April 21, 2011 at the WSIB shoulder and elbow specialty clinic. She continued to have pain in her left shoulder, along with pain in her arm, back, neck and right shoulder (GD2-172 ff.).

[19] Dr. Bob Karabatsos, an orthopaedic surgeon, saw the Appellant on August 19, 2011, for her left knee, which had been operated on June 6, 2011. The Appellant still had pain at the back of her knees. The doctor stated that he did not have any further surgical options for her, and did not recommend additional orthopaedic surgery. He expected that her pain would gradually improve (GD2-196).

[20] A return to work discharge report was provided to the WSIB on August 4, 2011. The Appellant returned to work in February 2011. She was off work from June 6 to July 1, 2011 for a knee injury. In June 2011 her shoulder precautions were deemed permanent (GD2-180-185).

[21] The Appellant had a left rotator cuff decompression/repair on March 2, 2012. Dr. M. McKee, an orthopaedic surgeon, reported on March 22, 2012, that she was doing very well and had excellent elbow and hand motion (GD2-186, 187, 221). On May 17, 2012, Dr. McKee stated that the Appellant could return to work on modified duties in two weeks, with restrictions for the left arm. He recommended graduated hours and ongoing physiotherapy (GD2-189-190).

[22] On May 16, 2012, an X-ray of the right knee showed mild osteoarthritis. On June 22, 2012, an MRI of the right knee showed knee joint effusion, chondromalacia, and a tear of the medial meniscus posterior horn (GD2-192-193). The Appellant had a right knee arthroscopy on October 10, 2012 (GD2-198).

[23] In August 2012, Dr. Karabatsos gave the Appellant an injection in her left knee for pain (GD2-194).

[24] A bone scan dated November 27, 2012 showed "severe right and moderate left knee uptake bilateral feet uptake suspicious for arthritic change." The Appellant saw Dr. Karabatsos on January 16, 2013 for pain in her hands, feet, back, and hip. A bone scan showed multiple "focal sites of involvement." The doctor stated that she had multi focal osteoarthritis, and that surgery would not help her. He recommended referral to a rheumatologist and pain medication (GD2-199, 200).

[25] The Appellant had an X-ray of her right ankle and foot on January 29, 2013. There was mild degenerative arthritis of the intertarsal joints and calcification and/or ossification at the site of insertion of the Achilles tendon (GD2-201).

[26] The Appellant fell and injured her right knee and ankle on February 17, 2013. In May 2013 she had a problem with swelling and tenderness in her left knee. She was given a prescription for Naprosyn (NSAID). Her left knee was still swollen and painful in July 2013 (GD2-78).

[27] The Appellant saw a rheumatologist, Dr. Raman Joshi, for joint pain on June 3, 2013. She had been experiencing constant pain in her feet, knees, and back that had begun two or three years before. On examination, she had eighteen out of eighteen tender spots. Dr. Joshi tentatively diagnosed osteoarthritis and fibromyalgia, ordered some blood work, and made some medication changes (GD2-43-44).

[28] X-rays dated July 2, 2013, showed mild to moderate osteoarthritis in the sacroiliac joint and both knees; degenerative disc disease, mild to moderate in the lower thoracic spine and moderate at several levels of the lumbar spine; mild L4-L5 and L5-S1 osteoarthritis; and osteoarthritis that was mild in the first MTP joints and mild to moderate in the dorsal mid foot (GD2-218-219).

[29] The Appellant stopped work on October 25, 2013, after her employer advised her that modified duties were no longer available (GD2-223).

[30] Dr. Jeffrey Karp, a psychologist, provided a psycho-vocational assessment report on January 31, 2014. He reported that the WSIB had provided precautions for the Appellant's left shoulder only: no heavy lifting; no repetitive forceful use of her left arm away from the body; and no work above chest level. The Appellant reported that she had constant pain in her left shoulder and lower back that radiated into her neck. She sometimes experienced sudden sharp pain and had to sit down. The pain was at a level of five out of six on a good day, and eight out of ten on a bad day. Her medications were Tramadol (opioid painkiller), Ratio-Lenoltec (with codeine), Elavil (for sleep), and Eletriptan (for headaches).

[31] Dr. Karp found that the Appellant's reading skills were at an elementary level, and her ability to read and write English was basic. Her spoken English was at a basic conversational level. She had never used a computer and had failed typing in school. She had always done laboring work, and had minimal residual transferable skills. She was interested in retraining. Her intellectual abilities were in the borderline to extremely low range, which would indicate that she could upgrade to approximately a mid to late elementary school level. She was not suited to undertaking a post-secondary education. She would be "a suitable candidate for training on the job for fairly routine duties, using simple tools under consistent supervision." She would likely be able to enhance her skills in the longer term using hands-on learning

methods. Retraining might prove therapeutic. Dr. Karp suggested basic clerical and sales positions as suitable for her (GD7).

[32] The office notes of Dr. Manu Dhillon, the Appellant's family physician, indicate that in February 2014, the Appellant had trouble with her left shoulder, which was painful when she moved. She complained of a headache (GD2-82).

[33] The Appellant saw Dr. Jagtaran Dhaliwal, a psychiatrist, on June 30, 2014 for anxiety and panic attacks. He found "no gross organicity," but a high level of anxiety. The diagnoses were panic, anxiety, and depression likely unipolar, and rule out bipolar. She complained of headaches characteristic of mild to moderate migraines, and of poor sleep. He recommended changes in diet and exercise, and prescribed 10 mg. of Cipralex in the evening. He would see the patient again in six weeks (GD2-36). The prescription record shows that the Appellant received prescriptions from Dr. Dhaliwal in January, April, July, September, and October 2015 (GD6-13 ff.).

[34] Dr. Dhillon's office notes record that in July 2014 the Appellant was working at a flower shop as part of a retraining program. She was cutting flowers all day, going in and out of the cooler. She now complained of pain in her back and shoulders. The doctor tried the Appellant on Mobicox and referred her for massage therapy. In September she reported pain in her right shoulder after being asked to lift a bucket of water at work. Her right shoulder was now worse than her left. She had an ongoing problem with pain in both shoulders and both knees, along with generalized body ache. In October 2014, the Appellant complained of severe pain in her left shoulder, lower back, and knees. She had trouble sleeping. She was using Mobicox (NSAID) and Tramadol. In November 2014, she had severe pain in her right knee, and ongoing pain in her shoulder (GD2-86).

[35] An X-ray of the right shoulder dated November 28, 2014, showed a very small tear of the infraspinatus tendon, a degenerative cyst, and moderate osteoarthritis of the acromioclavicular joint (GD2-38).

[36] The Appellant's CPP questionnaire was received on December 9, 2014. She had stopped working in October 2013 because her employer did not have modified work for her. She was

looking for work. She had a WSIB claim for injuries to her left shoulder and back that were incurred in 2008, but she was not getting any benefits from the WSIB. She had limitations sitting, standing, walking, lifting, carrying, and bending. She had trouble sleeping, concentrating, and remembering. She had difficulty with household chores, and with washing her hair and dressing. She could drive a car for half an hour (GD2-223-230).

[37] The CPP medical report of Dr. Dhillon was received on February 24, 2015. She had known the Appellant since 2006, and started treating her for the main medical condition in March 2008. She had last seen her in December 2014. The diagnoses were medial meniscal tear of the left knee, bilateral rotator cuff tears, depression, panic and anxiety, chronic pain of the shoulder and knee, and low back pain. The Appellant had ongoing pain in the shoulder with restricted range of motion in the left shoulder. She now had pain in her right shoulder with restricted range of motion. She had chronic pain in both knees, and occasional locking of the knee. She had a history of depression and anxiety. Further physiotherapy was planned, and another consult with a rheumatologist. She was taking Celebrex (NSAID) and Cipralex (anti-depressant) along with Sequel (Seroquel?). She had taken Amitriptyline in the past. Her prognosis was guarded (GD2-100-103).

[38] An MRI of the right knee, dated March 26, 2015, showed a small joint effusion, smaller than before, and medial and patellofemoral osteoarthritis with some progression. The medial meniscal tear was no longer visible (GD6-2). An MRI of the cervical spine dated August 28, 2015, showed mild multilevel degenerative disc disease in the central cervical spine, with a slightly improved appearance at C5-C6 (GD6-4).

[39] Dr. Nemer El-Batnigi, a family physician at a pain clinic, saw the Appellant on May 5, 2015, for neck, shoulder, and knee pain. The Appellant testified that it had taken at least three months to get this appointment after the referral was made. The doctor reported that the Appellant's neck pain was associated with headache and migraines. The benefits of rotator cuff surgery had been short-lived, giving her only about 20 per cent relief. She had 11 out of 18 tender points for fibromyalgia. Most of the time, her pain was at a level of ten out of ten. She was taking Tramadol and Naproxen, and was on medication for migraine headaches. She suffered from insomnia and depression. On examination, she had tenderness over her neck and

shoulders, and over the muscles of both her thoracic and lumbar spine. There was a minimal range of motion of the lumbar spine. The doctor recommended nerve block facet joint injections, as well as sciatica and pudendal blocks. Injections had not proven helpful in the past, so she declined them. He added Lyrica to her medication list (GD6-6 ff.).

[40] On September 8, 2016, Dr. El-Batnigi reported that he had seen the Appellant every week or two for nerve blocks and trigger point injections for the past four months. She did not tolerate the injections very well, and still had pain in the upper back and both her shoulders and neck radiating to both arms. Her daily function had not improved significantly after the injections. She had started using the fentanyl patch, which took the edge off her pain. The diagnosis was neuropathic and myofascial pain. The patient was reluctant to have Botox injections, but he gave her nerve blocks and trigger point injections that day (GD6-10).

[41] A pharmacy medication list covering the period January 2015 to December 2016 indicates that the Appellant received prescriptions for five different anti-depressants during this period, as well as Xanax (for panic). She also received prescriptions for three different painkillers (Tramadol, Gabapentin, and Fentanyl), along with a prescription for Zopiclone (for insomnia). She took Eletriptan for migraine headaches (GD6-11-18).

[42] On February 9, 2016, Dr. Dhillon wrote to the Appellant's representative that her patient had been on Tramadol, two tablets, three times a day, for left shoulder pain, and Ativan because she could not sleep at night due to shoulder pain (GD3-3).

[43] An MRI of the thoracic spine dated March 5, 2016, showed multilevel degenerative changes, particularly at T10-T11 where there was some acquired central canal stenosis. An MRI of the lumbar spine dated March 6, 2016, showed degenerative changes of the lower lumbar spine, most prominent at L4-5, where there was moderate central canal stenosis. This was the result of degenerative disc and facet changes as well as grade 1 anterolisthesis and a congenitally narrow canal (GD3-4-7)

[44] On January 2, 2017, Dr. Dhillon wrote that the Appellant had a long history of health difficulties, and referenced her shoulder and knee surgery. She was now suffering from bilateral knee arthritis; she said she was attaching an MRI from March 2016, but it was not in the file.

The Appellant had chronic pain in the back and lower spine, as indicated on the MRI. She had been treated at the chronic pain clinic since May 2015 and had no relief from injections or pain killers. She had been under the care of Dr. Dhaliwal for anxiety, panic attacks, and "questionable unipolar depression." In the past, she had used Alprozolam, Citalopram, Cymbalta, and Gabapentin. Dr. Dhaliwal had tried her on Trazadone in April 2013. She was taking Tramacet for pain and Ativan for anxiety. She was unable to work because of pain in her shoulder, neck, and back, along with depression and anxiety (GD5).

Appellant`s testimony

[45] The Appellant testified that she still suffered from pain in her neck, back, and shoulders. Treatment had been of limited assistance. Surgery had brought only about a 15-20 per cent decrease in her back and shoulder pain. Pain medication negatively affected her memory, and reduced her pain level only minimally. Further, Dr. El-had given her injections from her sacroiliac joint all the way to her neck in 2016, ultimately giving her ten injections a week. However, this treatment did not work and she had stopped seeing Dr. El-Batnigi. She had been seeing her psychiatrist, Dr. Dhaliwal, every two months for the past two years. He had tried her on many different medications. A major difficulty was that she slept very poorly because of the pain – only an hour or two at night. Her depression followed her pain, and she often wondered why she was living that kind of life.

[46] With regard to her functional limitations, the Appellant testified that she could sit or stand for only about 20 minutes. She received help from family members for cooking and cleaning, as well as reaching. She did not often go out because of her pain levels, although she had been very social before her accident. She did not drive alone because she was prone to forget where she was going, and did not drive on the highway; this had been true for the past four years. Her husband did the grocery shopping. Her ability to do anything around the house fluctuated depending on her pain levels and how much sleep she got the night before.

[47] The Appellant testified that she had come to Canada in 1982, when she was about 15 years old. She had spent about half a year in Grade 11, and then entered the workforce. She had always done factory work, usually general labour. In 2008, a cart full of metal parts fell on her, and she hurt her neck, lower back, and left shoulder. She went right back to work on the day of

the accident. After two or three months, she went to see her family doctor, and was put on modified duties. Her work included small jobs like putting things together with screws or putting stickers on boxes. She was able to take a lot of breaks and do stretching exercises. She continued to perform modified duties until her employment was terminated in October 2013. She had kept working during the FRP, when she received treatment for three to four hours a day.

[48] The Appellant was retrained under the auspices of the WSIB for about six months in 2014. She was trained in customer service and also had some English language upgrading. Then she had a month of job search training, after which the WSIB terminated her benefits. She worked at a flower store for about three months, answering phones and retrieving flowers from the cooler. The job, however, involved some physical work, such as lifting buckets containing water, and she was unable to maintain this employment. The Appellant was not sure when exactly she had stopped doing this job, but she thought it was in the summer of 2014.[1] She tried looking for alternate work, but when she told potential employers about her health conditions, they turned her away. She did not think she could work because of her pain levels, sleep deprivation, memory loss, and lack of patience.

SUBMISSIONS

[49] In response to the denial of her application at the initial level, in correspondence dated July 20, 2015 (GD2-13-14), the Appellant submitted that she qualifies for a disability pension because:

a) She suffers from a number of medical conditions that rendered her "totally disabled from any form of gainful employment at present and indefinitely;"

b) Her pain syndrome and psychological conditions are permanent; and

c) She was unsuccessful in obtaining alternate employment because of the severity of her medical condition.

[1] Dr. Dhillon's notes indicate that she was still working at the flower shop in September 2014. There is no further reference in the file to the Appellant working after that time.

[50] At the hearing, the Appellant submitted that she had suffered from a disability that was severe and prolonged since approximately December 2014, when she could no longer work. In addition:

a) As Dr. Dhillon`s letter of February 2017 indicated, the Appellant is suffering from back and knee pain, and had been treated without significant benefit;

b) Her physical and mental health conditions render her unemployable;

c) In spite of attending at a pain management clinic and being compliant with recommended treatments, she still suffers from chronic pain and depression;

d) She made significant efforts to continue working, trying modified duties, retraining, and undertaking alternate employment, but her physical condition deteriorated to the point where she could no longer work; and

e) The Appellant has always worked in physically demanding jobs. Her limited education and English skills, along with her physical and mental health conditions, make her unemployable.

[51] In submissions received on February 3, 2017 (GD8), the Respondent submitted that the Appellant does not qualify for a disability pension because:

a) She had surgery on her knees in 2011 and 2012 and a rotator cuff repair in March 2012;

b) Dr. Karabatsos reported that she had significant pain relief as a result of her left knee arthroscopy;

c) When Dr. Joshi examined her in June 2013, the exam findings were grossly normal;

d) Examination findings at the pain clinic in 2015 did not indicate severe limitation or impairment;

e) The Appellant did not want further injections and there was no follow-up regarding augmented pain medication;

f) Her medications were conservative and consistent throughout 2016;

g) Her headaches are managed with medication;

h) In June 2014, mental status findings did not show severe impairment;

i) Imaging reports showed no severe pathology;

j) A functional restoration program doctor indicated in 2011 that the Appellant could perform activities at the sedentary physical demand level with functional precautions; and

k) There is no indication that she attempted to return to modified work even though she has had treatment since she stopped working.

[52] In an Addendum to the Submissions of the Minister, received on February 27, 2017 (GD9), the Respondent stated that additional information received did not indicate that the Appellant had a severe and prolonged disability by the date of her MQP. In particular, the psycho-vocational assessment indicated that the Appellant was a suitable candidate for on-the-job training, as well as longer-term skills enhancement using hands-on learning methods.

ANALYSIS

[53] The Appellant's testimony appeared to be straightforward and was generally in agreement with the medical evidence. When there was something she could not remember, she so indicated. The Tribunal found that her testimony was credible.

[54] The Appellant's position was that her condition deteriorated significantly in 2014 and that the date of onset was December 2014. Accordingly, the decision will focus primarily on the Appellant's condition after 2012.

[55] The Federal Court of Appeal has held that "claimants still must be able to demonstrate that they suffer from a 'serious and prolonged disability' that renders them 'incapable regularly of pursuing any substantially gainful occupation.' Medical evidence will still be needed" (*Villani v. Canada (Attorney General),* 2001 FCA 248 [*Villani*], at para. 50). The Tribunal notes

that there is objective evidence of the Appellant's physical conditions. A bone scan dated in November 2012, after the Appellant had undergone surgery on both knees, showed probable arthritis in both knees, severe on the right and moderate on the left. An MRI of March 2015 showed some progression in the arthritis in her right knee. An MRI of the cervical spine taken in August 2015 revealed mild degenerative disc disease. In March 2016, and MRI showed central canal stenosis in the thoracic spine and moderate central canal stenosis at L4-5 of the lumbar spine. Although the Appellant had surgery on her left shoulder in October 2011, the WSIB endorsed a number of precautions for this shoulder when instructing Dr. Karp prior to his January 2014 assessment. An X-ray in November 2014 showed a tendon tear and moderate osteoarthritis in the right shoulder.

[56] Although the Appellant had bilateral knee surgery, as well as left shoulder surgery, Dr. Dhillon reported in February 2015, based on a December 2014 appointment, that she had chronic pain in both knees and both shoulders, along with lower back pain. The Respondent submitted that examination at a pain clinic in 2015 did not indicate any severe limitations. The Tribunal notes, however, that in 2015 Dr. El-Batnigi stated that the Appellant had minimal range of movement in her lumbar spine, and tenderness over the muscles in her neck, back, and thoracic and lumbar spine. He went on to give her several months of injections the following year, and tried her on the Fentanyl patch.

[57] A number of specialists provided diagnoses of the Appellant's condition. In January 2013, Dr. Karabatsos reported that a bone scan showed osteoarthritis in multiple locations. Surgery was not indicated, and he recommended referral to a rheumatologist. In June 2013, Dr. Joshi diagnosed fibromyalgia and osteoarthritis. The Appellant was diagnosed with chronic pain syndrome as early as 2009, a conclusion that was confirmed more recently by her family doctor. In addition, Dr. El-Batnigi wrote that she had neuropathic and myofascial pain. It is well known that fibromyalgia, chronic pain, and myofascial pain do not show up on imaging reports. The Appellant also complained of headaches associated with her neck and shoulder conditions, another health problem that is not captured in imaging reports. No physician indicated any doubt about the severity of her symptoms.

[58] With regard to her mental health, Dr. Dhaliwal reported in July 2014 that the diagnoses were panic, anxiety and depression. In 2017 Dr. Dhillon stated that the Appellant had been seeing Dr. Dhaliwal for treatment, which the Appellant said had been underway for two years at the time of the hearing. The psychiatrist had tried her on many different medications, according to her testimony, which is confirmed by her prescription record for 2015-2016.

[59] The Appellant has undergone numerous treatments for her medical condition. She has seen a number of pain specialists, two rheumatologists, and a psychiatrist. She had injections in her spine in July 2009, her shoulder in November 2009, nerve block injections in March 2010, injections in her left knee in August 2012, and nerve block and trigger point injections over her entire spine in 2016. She attended at two pain clinics, and at the FRP. In 2009, she was reported to have tried anti-inflammatories and pain killers, along with physiotherapy and massage therapy. She tried numerous types of medication, including pain killers, anti-depressants, headache medication, and a prescription sleep aid. Treatment was reported to have been of minimal benefit.

[60] According to the Federal Court of Appeal, an appellant must follow reasonable treatment recommendations, or provide a plausible explanation for their failure to do so (*Lalonde v. MHRD*, 2002 FCA 211). The Respondent submitted that in 2015 the Appellant did not want any more injections, and that there was no follow-up regarding augmented pain medications. The Tribunal observes, however, that, as noted above, the Appellant had already undergone numerous courses of injections, and took a further series of injections in 2016. Further, Dr. El- Batnigi prescribed Lyrica and the Fentanyl patch for her in 2015-2016. Accordingly, the Tribunal is not persuaded by the Respondent's submissions on this point. Further, the Tribunal finds that, more generally, the Appellant showed a good-faith preparedness to follow obviously appropriate medical advice.

[61] Taking into account the Appellant's multiple physical conditions, as well as her mental health issues and the many treatment regimes she followed without notable benefit, the Tribunal finds that she had a serious medical condition.

[62] The Federal Court of Appeal, however, has held that it is not the diagnosis of the disease, but the Appellant's capacity to work, that "determines the severity of the disability under the CPP" (*Klabouch v. Canada (Social Development)*, 2008 FCA 33, at para. 14). Moreover, where there is evidence of work capacity, a person must show that efforts at obtaining and maintaining employment have been unsuccessful by reason of their health condition (*Inclima v. Canada (Attorney General)*, 2003 FCA 117 [*Inclima*]).

[63] The only formal evidence of work capacity was the FRP report of early 2011, which stated that the Appellant was capable of sedentary level physical work with precautions. At the time of the report, the Appellant was still working, and worked for almost another two years. Her condition deteriorated thereafter, as documented in the medical evidence. The Tribunal does not accept the Respondent's submission that the 2011 report is a valid reflection of the Appellant's work capacity three years afterwards.

[64] Although the Respondent submitted that the Appellant had not undertaken alternate employment, Dr. Dhillon's office notes for July and September 2014 show, and the Appellant's testimony confirmed, that she found a new job in 2014. The Appellant credibly testified that she had undergone a retraining program sponsored by the WSIB, along with job search training. She was able to obtain a job in flower shop, and tried this for three months. She could not continue because the job involved heavy lifting and working in a cold environment, which aggravated her condition. The Tribunal finds that this was a failed work attempt. The Appellant stated that she had looked for other work, and was unable to find it because of her physical condition. She provided no documentary evidence of other work attempts, but her explanation rings true. The Appellant clearly has a strong work ethic, having worked from the age of sixteen, and having continued with her employment on modified duties in spite of numerous surgeries and an FRP. She had been keen on the prospect of being retrained. The Tribunal is persuaded that the Appellant would have continued working if she had been able to find employment suitable to her physical condition and educational limitations. The Tribunal finds that the Appellant was unable to maintain employment because of her health condition and, accordingly, meets the terms of the *Inclima* test.

[65] The Federal Court of Appeal has endorsed the statement that "predictability is the essence of regularity within the CPP definition of disability…. (*Atkinson v. Canada (Attorney General*), 2014 FCA 187, at para. 37-8). In the present case, the Tribunal is not persuaded that the Appellant would have been a reliable employee because of the unpredictability of her pain levels and insomnia.

[66] The severe criterion must be assessed in a real world context (*Villani,* at para. 38). 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. The Tribunal notes that the Appellant was in her fifties at the time of the MQP and had always worked at physically demanding jobs. The psycho-vocational assessment of January 2014 addressed many of the *Villani* factors. The Respondent has stressed Dr. Karp's opinion that the Appellant was a candidate for on-the-job training. However, the Tribunal has given greater weight to Dr. Karp's findings that the Appellant had only rudimentary English language skills, was not computer literate, and would need upgrading to achieve something less than an elementary school education. She had minimal transferable skills after more than two decades of physical labour. Given these factors, along with her physical and mental health conditions, the Tribunal finds that the Appellant meets this aspect of the *Villani* test for severity.

[67] The Tribunal is satisfied, on a balance of probabilities, that the Appellant's disability was severe on or before her MQP.

Prolonged

[68] The Appellant has suffered from knee, shoulder, neck and back pain for many years, and from depression, anxiety and panic attacks since at least 2014. Thus her disability is long continued. No health professional has stated that her condition would improve, and in fact the medical evidence shows that it has deteriorated. Thus her disability is of indefinite duration.

[69] Accordingly, the Tribunal finds that the Appellant's disability is prolonged.

Conclusion

[70] The Tribunal has carefully considered the point at which the Appellant's disability became severe. In December 2014, Dr. Dhillon reported that the Appellant had pain and a restricted range of motion in both shoulders, as well as chronic pain in both knees and lower back pain. She did not say how severe these physical problems were. However, in July 2013, X-rays showed mild to moderate osteoarthritis in numerous locations. The Appellant had also long complained of insomnia, headaches, and memory difficulties, and two rheumatologists had diagnosed signs of fibromyalgia. By January 2014, she was taking two opioid painkillers, a sleep aid, and headache medication. In November 2014, an X-ray showed a tear in a tendon in her right shoulder. In June 2014, a psychiatrist diagnosed panic, anxiety, and depression, and put her on medication, which he adjusted often until at least until the end of 2015. By December 2014, she had stopped working. The Tribunal is satisfied that by December 2014, the Appellant was unable to perform physical work because of her health conditions. Further, Dr. Karp's report supports a conclusion that she was unsuited to a sedentary occupation because of limitations in the areas of education, language, and aptitude. The Tribunal is persuaded that the Appellant's disability was severe by December 2014.

[71] The Tribunal finds that the Appellant had a severe and prolonged disability in December 2014 when she was no longer able to perform physical work. According to section 69 of the CPP, payments start four months after the date of disability. Payments start as of April 2015.

[72] The appeal is allowed.

Carol Wilton
Member, General Division - Income Security