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

Citation: *J. H. v. Minister of Employment and Social Development*, 2017 SSTADIS 145

Tribunal File Number: AD-16-409

BETWEEN:

J. H.

Appellant

and

Minister of Employment and Social Development

Respondent

SOCIAL SECURITY TRIBUNAL DECISION

Appeal Division

DECISION BY: Janet Lew

DATE OF DECISION: April 5, 2017

REASONS AND DECISION

OVERVIEW

[1] This is an appeal of the decision of the General Division rendered on December 29, 2015, which determined that the Appellant was not eligible for a disability pension under the *Canada Pension Plan*, as it found that his disability was not "severe" on or before the end of his minimum qualifying period on December 31, 2014.

[2] I granted leave to appeal on August 9, 2016, on one ground, under paragraph 58(1)(*c*) of the *Department of Employment and Social Development Act* (DESDA). The parties made additional submissions in respect of this ground. As neither party requested a hearing, and as I have determined that no further hearing is required, this appeal is proceeding under paragraph 43(*a*) of the *Social Security Tribunal Regulations.*

ISSUES

[3] The following issues are before me:

a. Can the Appeal Division consider new evidence on an appeal?

b. Did the General Division base its decision on an erroneous finding that it made in a perverse or capricious manner or without regard for the material before it, when it found that there were no clinical records of the family physician?

GROUNDS OF APPEAL

[4] Subsection 58(1) of the DESDA sets out the following grounds of appeal:

(a) the General Division failed to observe a principle of natural justice or otherwise acted beyond or refused to exercise its jurisdiction;

(b) the General Division erred in law in making its decision, whether or not the error appears on the face of the record; or

(c) the General Division based its decision on an erroneous finding of fact that it made in a perverse or capricious manner or without regard for the material before it.

ISSUE A: NEW EVIDENCE

[5] The Appellant filed updated medical reports dated March 23, 2016, and August 9, 2016, from his family physician, in support of his appeal. In a letter dated September 28, 2016, the Social Security Tribunal asked the Appellant how the latest medical report addressed any grounds of appeal under subsection 58(1) of the DESDA. In his letter of October 4, 2016, the Appellant explained that the report was vital to show the ongoing nature of his conditions.

[6] It has now become well-settled law that new evidence (i.e. the diagnostic examination) does not constitute a ground of appeal. As the Federal Court recently held in *Marcia v. Canada (Attorney General)*, 2016 FC 1367:

> [34] New evidence is not permissible at the Appeal Division as it is limited to the grounds in subsection 58(1) and the appeal does not constitute a hearing *de novo*. As Ms. Marcia's new evidence pertaining to the General Division's decision could not be admitted, the Appeal Division did not err in not accepting it (*Alves v Canada (Attorney General)*, 2014 FC 1100 at para 73).

[7] As the updated medical reports do not address any of the grounds of appeal, I am unable to accept or consider them for the purposes of this appeal.

ISSUE B: ERRONEOUS FINDING OF FACT

[8] In his application requesting leave to appeal, the Appellant submitted that the General Division based its decision on an erroneous finding of fact made without regard for the material before it, when the General Division wrote at paragraph 55 that, "There are no clinical notes from regular visits with the family physician." He suggested that the General Division could not have properly evaluated his appeal if the member found that there were no clinical notes, when in fact there were clinical notes in the hearing file.

[9] As I indicated in my leave decision, there is a distinction between clinical notes or records *per se* and reports. Clinical notes represent a medical practitioner's "minutes" of his or her consultation with a patient, usually prepared contemporaneously or shortly after a patient's visit. Clinical notes are generally intended to document a patient's complaints and a physician's observations and findings, whereas a medical report, typically in narrative form, is more expansive. Typically, not only will a medical report list any symptoms and diagnoses, but generally it will also include a medical and family history, investigative results, treatment history and options, and prognoses. A medical report represents a factual summary of the information in a physician's medical file pertaining to the patient, with a focus on a patient's most pronounced issues.

[10] The hearing file before the General Division included the family physician's medical reports. After all, the member referred to several of the medical reports in her analysis, at paragraphs 28, 29, 34 and 40. Therefore, I conclude that when the member wrote that there were "no clinical notes," she was referring to the physician's notes that are typically made contemporaneously or shortly after a patient's visit.

[11] A review of the hearing file indicates that the family physician's clinical notes can be found at pages GD3-18 to 20, GD13-2 and GD13-3. The notes relate to six visits from February 18, 2013, to August 26, 2013, and three visits from November 18, 2014, to April 16, 2015. In the face of this evidence, *prima facie* the General Division erred in unequivocally stating that there were no clinical notes from the family physician. However, one must examine the context in which the General Division found that there were "no clinical notes from regular visits with the family physician."

[12] Paragraph 55 begins with an acknowledgment that the Appellant reported that he also had migraine headaches, irritable bowel syndrome, mental health symptoms and body pain. (It is unclear what "body pain" refers to, given that the member addressed the Appellant's complaints of fibromyalgia and widespread chronic pain, particularly in his back, earlier in her analysis.) The General Division agreed with the Respondent that there was a lack of objective medical evidence about these other medical issues, noting firstly that there were "no clinical notes from regular visits with the family physician." In this context,

clearly, the General Division member contemplated that there were no clinical records that dealt with the Appellant's migraine headaches, irritable bowel syndrome, mental health symptoms and body pain.

[13] In this regard, one needs to review the clinical records to determine whether they meaningfully and regularly address the migraine headaches, irritable bowel syndrome, mental health symptoms and body pain (i.e. other than the chronic pain, including in his back). After all, the member looked to see if there were "regular visits." The member also noted that there was other medical evidence that addressed the Appellant's complaints of migraine headaches and irritable bowel syndrome. Indeed, the member referred to the medical opinion, dated January 26, 2011, of Dr. G. Singh, psychiatrist and neurologist, that the Appellant's headaches did not meet the diagnostic criteria for migraines. The member also found that there was no objective information that he had been diagnosed with irritable bowel syndrome and that he was being treated by a specialist for the condition.

[14] If the clinical records do not meaningfully add to the other medical evidence in the hearing file regarding the migraine headaches, irritable bowel syndrome, mental health symptoms and body pain, it is far less likely that they would have had any impact on the ultimate outcome of the proceedings. Conversely, if any of the family physician's clinical records meaningfully and regularly address the migraine headaches, irritable bowel syndrome, mental health symptoms and body pain, then it is more likely that the General Division made an erroneous finding of fact without regard for the material before it, upon which it based its decision.

[15] Put another way, if I am to find that the General Division made an erroneous finding of fact under subsection 58(1) of the DESDA, not only would it had to have made that finding in a perverse or capricious manner, or without regard for the material before it, but it would also had to have based its decision on that erroneous finding. It is highly doubtful that the presence of clinical records alone would be persuasive or determinative of the issue of whether an appellant is severely disabled. Rather, it should be the contents of those clinical records that hold sway. By way of comparison, there was a medical report from a neurologist, but the presence of this report alone did not convince the member of the

severity of the Appellant's headaches. Rather, the member looked beyond the mere presence of the report and examined the neurologist's opinion, to assess whether the Appellant's headaches were severe.

[16] I should conduct my review of the clinical records from this perspective, and determine whether the contents of the family physician's clinical records might have held any probative value.

[17] In his entry for February 18, 2013, the family physician recorded that the Appellant complained of a migraine headache as well as back symptoms. The family physician diagnosed him with chronic back pain (GD3-20).

[18] In his entry for April 5, 2013, the family physician documented complaints of neck symptoms, relieved with Voltaren gel. The family physician diagnosed him with chronic pain, neck pain and tenosynovitis on his left side (GD3-19). On July 10, 2013, the Appellant reported having neck and back pain. The family physician again diagnosed him with chronic pain. In the same month, the family physician diagnosed him with polyarthralgia. In the following month, the family physician recorded a first assessment for "JP pain." The family physician diagnosed him with chronic pain (GD3-18).

[19] The visit of November 18, 2014, largely related to the Appellant's migraine headaches and chronic pain (GD13-3). The February 19, 2015 visit with the family physician also addressed the Appellant's chronic pain syndrome, migraine headaches and irritable bowel syndrome. The April 16, 2015 visit did not specifically refer to any complaints of migraine headaches, irritable bowel syndrome, mental health symptoms and body pain, although the family physician diagnosed the Appellant with chronic pain (GD13-2).

[20] My review of the family physician's clinical records indicates that the Appellant complained of or was assessed as having migraine headaches on three occasions and irritable bowel syndrome on one occasion, between February 2013 and April 2015. However, there was no indication how the family physician came to these diagnoses or whether any further investigations were planned. On February 19, 2015, for instance, the

family physician did not document any complaints of headaches or other pain, other than "interm thigh aches," yet diagnosed him as having several medical conditions, including migraine headaches and irritable bowel syndrome. There was no indication that the family physician had referred the Appellant to other specialists either. In January 2011, Dr. Singh had already ruled out migraine headaches, so it is unclear how the family physician came to this diagnosis. After all, there have been no subsequent consultations with any neurologists or headache specialists. Similarly, as the member found, there is no documentary evidence that the Appellant has been seen and diagnosed by a specialist as having irritable bowel syndrome, to substantiate its severity.

[21] While the member erred in suggesting that there were no documented instances of migraine headaches or irritable bowel syndrome, given her analysis, I cannot envision that she would have come to a different conclusion regarding the severity of the migraine headaches or irritable bowel syndrome because of the limited information— mere cursory references— contained in the clinical records.

[22] The family physician's clinical records do not mention any mental health symptoms or issues and in that regard, the member did not err in finding that there were no clinical records from the family physician that dealt with the Appellant's mental health symptoms. I am not satisfied that the member erred in finding that there were no clinical records from the family physician that dealt with the Appellant's mental health symptoms or issues.

[23] Although the member's expression "body pain" in paragraph 55 is somewhat vague, as I have indicated, as the member had previously discussed the Appellant's chronic pain and fibromyalgia in her analysis, "body pain" likely refers to pain complaints other than the chronic pain and fibromyalgia. The clinical notes for April 5, 2013 bring up the issue of tenosynovitis on the left side (GD3-19). The General Division made no reference to the tenosynovitis in its decision. Yet, there is no other documentary reference to tenosynovitis in the hearing file. Had the tenosynovitis been a recurring or persistent issue, one would expect that it would have been mentioned elsewhere in the medical records, or that the family physician would have referred the Appellant to a specialist for further investigation and treatment. The General Division noted that the Appellant had been seen by

a rheumatologist in July 2014 for pain in his right wrist, amongst other things, but there was no mention of any left-sided tendon or joint pain in his left wrist in the rheumatologist's report or at any time after April 2013.

[24] In the entry of July 22, 2013, the family physician diagnosed the Appellant with polyarthralgia (GD3-18). The member did not refer to the family physician's diagnosis of polyarthralgia; however, the family physician referred the Appellant to a rheumatologist for further assessment, at which point the condition was investigated. The General Division focused on the rheumatologist's report in this regard.

[25] On this basis, I am not convinced that the member erred in finding that there were no clinical records from the family physician that dealt with other "body pain." The medical records contain a solitary reference to tendon pain in the left wrist, and the member considered the Appellant's polyarthralgia by looking at the rheumatologist's report.

[26] Further, it is clear that the member would have needed to be satisfied that the Appellant had regularly visited his family physician and regularly complained of migraine headaches, irritable bowel syndrome, mental health symptoms or other body pain. It is not even certain from the records that the Appellant complained of headaches on all three occasions or of irritable bowel syndrome on the one occasion, when the family physician documented these conditions, as the family physician simply provided a diagnosis of them without mentioning that the Appellant had complained of them. These limited occasions fall short of showing that there were "regular visits" to the family physician or that he regularly complained of migraine headaches or irritable bowel syndrome.

[27] If, in fact, the General Division did not intend to confine her remarks about the absence of clinical records to the issues of migraine headaches, irritable bowel syndrome, mental health symptoms and body pain, then I should look at the clinical records as a whole and determine whether they have any probative value and add much, if anything, to the family physician's medical reports or other experts' opinions.

[28] The family physician gave a summary of the Appellant's complaints, diagnoses and treatment recommendations in his medical reports, based on his clinical notes. In its letter of

September 28, 2016, the Tribunal asked the Appellant to essentially describe how the information in the clinical notes differed from the information in the other medical records before the General Division. The Tribunal asked him to identify any clinical records that showed that he was severely disabled. In particular, the Tribunal asked, "On what page(s) do these records or entries appear which you say shows that you were severely disabled?"

[29] The Appellant responded as follows:

> The clinical records from Dr. Perold are very important to getting a proper evaluation of me. Dr. Perold Continues to confirm my conditions and states there is no change. Some of these conditions are covered by Canada Disability all on their own. Chronic Migraine Headaches are covered. Arthritis is covered. Depression is covered. Widespread chronic pain as in Fibromyalgia is covered.
>
> Dr.Perolds Statements over the past five years are very important to establishing my prolonged and severe conditions. I Know he does not use the word severe. With adding up all my conditions and time suffering from these conditions I can't understand why I do not qualify for Canada disability benefits. After reading Dr. Perolds statements over the past five years Common Sense should prevail. [*sic*]

[30] The Appellant's response suggests that I should conduct a reassessment of the medical evidence. However, as the Federal Court held in *Tracey v. Canada (Attorney General)*, 2015 FC 1300, it is not the Appeal Division's role to conduct a reassessment when determining whether leave should be granted or denied, as a reassessment does not fall within any of the grounds of appeal under subsection 58(1) of the DESDA.

[31] The General Division addressed each of the subjective complaints and diagnoses set out in the family physician's clinical records, other perhaps than the complaints or diagnoses of polyarthralgia and tenosynovitis, but as I have indicated above, the member examined the polyarthralgia through the rheumatologist's report, and the tenosynovitis appears only once in the medical records.

[32] Given the limited utility of the family physician's clinical records, I am not satisfied that the member based her decision on an erroneous finding of fact made in a perverse or capricious manner or without regard for the material that was before her.

CONCLUSION

[33] The appeal is dismissed.

Janet Lew
Member, Appeal Division