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

Citation: *MA v Minister of Employment and Social Development*, 2021 SST 446

Tribunal File Number: GP-20-227

BETWEEN:

M. A.

Appellant (Claimant)

and

Minister of Employment and Social Development

Minister

SOCIAL SECURITY TRIBUNAL DECISION
General Division – Income Security Section

Decision by: Pierre Vanderhout

Teleconference hearing on: January 7, 2021

Date of decision: February 2, 2021

DECISION

[1] The Claimant is not entitled to a Canada Pension Plan ("CPP") disability pension.

OVERVIEW

[2] The Claimant is 66 years old. He has not worked since 2011, when he lost his job as a computer programmer. In 2013, he entered a training program at a local community college. This was also in the computer field. He only claims to have been disabled since October 2013, when he went to the emergency department. He reported diffuse weakness, severe vomiting, feeling lightheaded, inability to function, and nausea. He was released the next day with no definite diagnosis.[1] He thought he suffered a stroke. At the hearing, he said he was clinically dead at one point. However, the medical documents in the file do not support either of these two scenarios.

[3] This is the Claimant's second application for a CPP disability pension. He previously applied in January 2015, and eventually appealed to the Social Security Tribunal. However, he withdrew that appeal on February 28, 2017. The Minister received the Claimant's latest application for the disability pension on December 31, 2018. The Claimant said he was unable to work because of various cognitive issues, sleep disorders, limb weakness, and limitations with walking and standing.[2] The Minister denied the application initially and on reconsideration. The Claimant appealed the reconsideration decision to the Social Security Tribunal.

[4] To qualify for a CPP disability pension, the Claimant must meet the requirements set out in the CPP. More specifically, he must be found disabled (as defined in the CPP) on or before the end of the minimum qualifying period ("MQP"). The MQP calculation is based on his CPP contributions. I find his MQP to be December 31, 2013. However, he reached age 65 in August 2019. CPP disability pensions are not paid after age 65. Furthermore, his December 2018 application date means he could not receive CPP disability benefits before January 2018.[3] Thus, the only benefits in issue are those payable from January 2018 to August 2019.

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[1] GD2-176
[2] GD2-31
[3] See paragraph 42(2)(b) and section 69 of the *Canada Pension Plan.*

ISSUES

[5] Did the Claimant have a severe disability by December 31, 2013?

[6] If so, was the Claimant's disability also prolonged by December 31, 2013?

ANALYSIS

[7] Disability is defined as a physical or mental disability that is severe and prolonged.[4] The Claimant has a severe disability if he is incapable regularly of pursuing any substantially gainful occupation. His disability is prolonged if it is likely to be long continued and of indefinite duration, or is likely to result in death. He must prove, on a balance of probabilities, that he meets both parts of the test. If he meets only one part, he does not qualify for disability benefits.

Did the Claimant have a severe disability by December 31, 2013?

[8] For the reasons set out below, I find that the Claimant did not have a continuously severe disability since December 31, 2013. While he may have had a severe disability at that time, it has not been continuous since then.

[9] I must assess the severe part of the test in a real-world context.[5] This means that when deciding whether the Claimant's disability is severe, I must remember factors such as his age, level of education, language proficiency, and past work and life experience. In this case, the Claimant was 59 years old at his MQP date. He speaks both English and Arabic. He has a Bachelor of Commerce degree in Business Administration. He later took some university computer courses and had extensive on-the-job training in computer-related topics. For decades, he worked in computer-related occupations. He worked in many Programmer/Analyst positions. While many of these were in a mainframe computer environment, he also did some Internet-related work in Saudi Arabia. He also ran his own computer consulting company for about six years. He was the only employee. In October 2013, he was enrolled in a college computer

[4] Paragraph 42(2)(a) of the *Canada Pension Plan.*
[5] *Villani v. Canada (A.G.)*, 2001 FCA 248

program. Based on his background, and without considering his medical conditions, he would be suited for many sedentary computer-related positions.

[10] My next step would normally be to consider the impact of the Claimant's medical conditions. However, I must first address problems with the evidence from both the Claimant and Dr. Carbyn (Family Doctor).

Concerns with the evidence

[11] Dr. Carbyn prepared medical reports for both of the Claimant's CPP disability applications. In his September 2014 CPP report, he said the Claimant's diagnoses were cataracts, hypertension, impaired fasting glucose, and renal cysts/hydronephrosis. Dr. Carbyn did not give any functional limitations or physical findings: these had to await a second urology opinion. He said the same thing about the Claimant's prognosis.[6] I see no cognitive or mental concerns. However, in February 2019, Dr. Carbyn said the Claimant's main condition was impaired memory and concentration, related to a mood disorder or pseudo-dementia. He said the disabling condition went back to October 2013, and makes (at best) a passing mention of one of the September 2014 diagnoses (hypotension).[7] This is inconsistent with his previous CPP report, and makes me wary of relying on Dr. Carbyn's retrospective evidence.

[12] In 2019, Dr. Carbyn said the Claimant's cognitive behavioural therapy ("CBT") started in January 2015 and was ongoing.[8] In January 2015, Dr. Carbyn said he told the Claimant about treatment options for mood issues, and let him think about those options. In February 2015, the Claimant told Dr. Carbyn he preferred CBT.[9] Dr. Carbyn then made a referral to the Family Services Association.[10] Dr. McKnight (Memory Clinic) also recommended CBT in 2016.[11]

[13] However, this strongly conflicts with the Claimant's evidence. At the hearing, the Claimant denied ever having CBT. He said he asked for counselling, but never got any. When

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[6] GD2-344 to GD2-347
[7] GD2-159. In fact, the September 2014 diagnosis was hypertension, not hypotension. However, Dr. Carbyn repeatedly described the October 2013 episode as "hypotensive". Both relate to blood pressure.
[8] GD2-159.
[9] GD2-290 and GD2-292
[10] GD2-287 and GD2-292
[11] GD2-183

asked specifically about counselling with the Family Services Association, he then admitted not attending. He questioned the value of family counselling when he was no longer communicating with his family, and also suggested that financial concerns played a role.

[14] The Claimant's insistence that he had a stroke in October 2013 brings his retrospective evidence further into question.[12] He also claims to have had "brain death" in October 2013.[13] At the hearing, the Claimant claimed he was "clinically dead" at that time. However, a Neurologist specifically ruled out a stroke in February 2014, and I see no evidence of brain or clinical death.[14] The Claimant also repeatedly cites memory problems.[15]

[15] In the circumstances, I have concerns about the reliability of any "retrospective" evidence from either Dr. Carbyn or the Claimant. In other words, I cannot rely on evidence given long after the time in question. This means I cannot rely on evidence given in 2019 to determine what happened in 2013 or 2014. Instead, I must focus on evidence addressing contemporaneous (as opposed to past) events. I will now look at the Claimant's limitations since his MQP date.

The Claimant's limitations and work capacity since December 2013

[16] In his December 2018 application materials, the Claimant bases his claim mostly on mental and cognitive limitations.[16] This is consistent with Dr. Carbyn's reports in February 2019 and May 2019.[17] While Dr. Carbyn identifies other concerns, such as impaired fasting glucose, the limitations focus almost entirely on mental or cognitive concerns. While I must assess the Claimant's condition in its totality, and not just the biggest or main impairment[18], I find that the Claimant's physical issues have relatively little effect on his work capacity. Furthermore, in the "real-world context," the Claimant is only suited for sedentary computer-related work.

[17] The Claimant clearly had an upsetting event in October 2013 when he had to go to the emergency department. Around this time, he had anxiety related to school stress. Dr. Carbyn

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[12] GD2-165 and GD2-168, for example.
[13] GD2-12
[14] GD2-177
[15] See, for example, GD2-31, GD2-182, GD2-183, GD2-309, GD2-368, and GD2-369.
[16] GD2-31 and GD2-35 to GD2-37
[17] GD2-146 and GD2-155
[18] *Bungay v. Canada (A.G.)*, 2011 FCA 47

wrote a doctor's note on November 1, 2013. This note advised moving from full-time to part-time status at college, due to stress.[19] Soon after, it appears the Claimant withdrew from college altogether. He had another emergency attendance in December 2013, where he complained of memory and focus issues.[20] At this early stage, he might have had a severe disability. However, he must establish a continuous disability since then. I also note that the measure of whether a disability is "severe" is not whether he suffers from severe impairments. The question is whether the disability prevents him from earning a living.[21]

[18] The symptoms that sent the Claimant to emergency in December 2013 appear to have settled within a week.[22] He then identified various other concerns in 2014, including a neck mass, right foot discomfort, lower abdominal discomfort, urinary tract infections, right knee pain, and mild dyspnea on exertion.

[19] Following up the October 2013 episode, the Claimant first saw a specialist in February 2014. Dr. MacDougall (Neurology) noted that the Claimant had developed a sedentary lifestyle since the fall and gained over 20 pounds. His conditioning had deteriorated. Dr. MacDougall concluded he had acute gastroenteritis in October 2013. Dr. MacDougall saw no evidence of a stroke. Dr. MacDougall recommended that he improve his fitness and not live a sedentary life. Immediately after, the Claimant started exercising more and felt well.[23] In June 2014, Dr. Bell (Urology) recommended a cystoscopy and a retrograde examination to investigate lower abdominal discomfort. However, the Claimant refused to have the procedure.[24]

[20] In September 2014, Dr. Carbyn completed a report for the Claimant's first CPP disability application. As noted, the diagnoses were hypertension, impaired fasting glucose, cataracts, and a renal cyst/swollen kidney. Dr. Carbyn provided no limitations, treatment, or a prognosis, as the Claimant was waiting for a second urology opinion.[25] However, later that month, Dr. Carbyn noted decreased mood, anhedonia, increased anxiety, and decreased sleep. This was the first

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[19] GD2-294
[20] GD2-309
[21] *Klabouch v. Canada (A.G.)*, 2008 FCA 33
[22] GD2-294
[23] GD2-176 and GD2-293
[24] GD2-365
[25] GD2-344 to GD2-347

significant appearance of mental health symptoms since late 2013. Dr. Carbyn referred the Claimant to the Family Services Association Clinic.

[21] The Claimant's mood improved significantly in November 2014, when he spent a lot of time outside fishing, but he was again anxious in January 2015. When he completed a CPP disability form in January 2015, the Claimant said his illness involved diminished English skills. He also had issues with memory, follow-up and activity.[26] Dr. Carbyn again mentioned a referral to the Family Services Association Clinic in February 2015, and wrote a doctor's note for that purpose.[27] However, as discussed above, the Claimant denied ever attending.

[22] In July 2015, Dr. Carbyn said the Claimant had been anxious and depressed in January 2015, and psychological counselling was recommended. Dr. Carbyn's only comment on that counselling was "no voiced complaints since that time."[28] This hints at the possibility that the Claimant had not attended counselling. More importantly, it suggests he had no further symptoms since the early 2015 referral. The only other limitations noted in July 2015 (Dr. Carbyn's last report in the file until February 2019) were an arthritic right foot and some lumbar strain. Insoles and a walking program were recommended. I saw nothing further about these two complaints.[29]

[23] I see no further objective evidence of treatment for cognitive or mental issues until February 2016, when the Claimant saw Dr. McKnight. Dr. McKnight recorded symptoms of depression, inability to concentrate or process, and excessive sleep. Dr. McKnight reported a very mild memory problem, but the issue was really attention and concentration. However, Dr. McKnight did not think it was affecting the Claimant's function. As this appeared to be a mood disorder (and may have existed for more than a decade), Dr. McKnight recommended that Dr. Carbyn prescribe an antidepressant and make a CBT referral.[30] At the hearing, the Claimant denied ever getting an antidepressant and said Dr. Carbyn never talked to him about it. As noted, he also denied ever having CBT. I see no further mention of any cognitive impairment until

[26] GD2-290 and GD2-368
[27] GD2-287 and GD2-292
[28] GD2-285
[29] GD2-155 to GD2-163 and GD2-285
[30] GD2-181 to GD2-183

October 2018, when Dr. Rendon (Urology) described it as "very mild".[31] Notably, I see no objective medical evidence between April 2016 and October 2018.[32]

[24] Given all this evidence, I find that the Claimant has likely had at least some work capacity for much of the time since December 2013. There is no evidence of any mental or cognitive issue for a significant part of 2014. In September 2014, Dr. Carbyn said the only potential functional limitations would be urological concerns.[33] The Claimant may have had brief mental or cognitive flares in early 2015 and early 2016, but they appear to have resolved and the impact was very mild. After that, I see no notable mental or cognitive issues until 2019: the October 2018 report says the cognitive impairment was "very mild". There is also a period of two-and-a-half years with no medical documents at all. My findings are problematic for the Claimant, because he has not pursued or applied for any work since leaving school in 2013. In fact, in December 2018, he suggests that he did not pursue work or school because he did not want to suffer another stroke.[34] This was long after February 2014, when Dr. MacDougall told him that he did not suffer a stroke. Dr. MacDougall told him that he should improve his fitness and discontinue his sedentary lifestyle.[35] I see no mention of a stroke by Dr. Carbyn either.

[25] Where there is evidence of work capacity, a person must show that efforts at obtaining and maintaining employment have been unsuccessful because of his health condition.[36] The Claimant cannot show that in this case. He has not pursued any work or training since 2013. This means his appeal cannot succeed.

Other submissions by the Claimant

[26] The Claimant has made many submissions over the years. The above analysis addresses some of them. I will now address some of the others.

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[31] GD2-186
[32] GD2-184 and GD2-250
[33] GD2-345
[34] GD2-168
[35] GD2-177
[36] *Inclima v. Canada (A.G.)*, 2003 FCA 117

[27] The Claimant said he knew somebody who did construction work but still received CPP disability benefits.[37] He says this is unfair. However, I can only assess whether the Claimant meets the CPP requirements for disability. Another person's activities are irrelevant to that assessment.

[28] The Claimant also questioned the competence of many people who treated his claimed disability. He said his treatment at the Dartmouth General Hospital (where he attended emergency in 2013) was inadequate. He said he rejected any report that ignored his "brain death" and said he was in good condition. He said the doctors did not know why he was there.[38] At the hearing, he said the hospital's reports were not correct. He was apparently told that the ambulance driver wrote the reports.

[29] In late 2018, the Claimant said Dr. MacDougall only spent five minutes with him in February 2014, and offered no useful diagnosis of his condition. He suggested Dr. MacDougall was too busy, due to travel commitments. He later said Dr. MacDougall based his February 2014 report entirely on what the Dartmouth General Hospital said in late 2013, without reviewing the Claimant's current symptoms.[39]

[30] The Claimant said his second specialist consultation (which he attributed to 2015, but was likely the 2016 appointment with Dr. McKnight) was also inadequate. Although the doctors spent more than an hour with him, they apparently did not examine the "growing parts" of his head.[40] He said they were unlicensed "training doctors," under the supervision of a professor. As a result, he said he could refuse their report.[41]

[31] In support of his allegations, the Claimant provided links to online reviews of Dartmouth General Hospital and Dr. MacDougall. However, I am not prepared to rely on unverified online reviews to assess the credibility of doctors. Nor does the involvement of specialists-in-training raise any concerns, as a specialist supervised their work. I see nothing in the documents to justify ignoring any of the impugned evidence, particularly given my concerns about the Claimant's

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[37] This person may be the one mentioned at GD2-50.
[38] GD2-12
[39] GD2-13 and GD2-166
[40] GD2-166
[41] GD2-13

retrospective evidence. I acknowledge that the Claimant may not agree with the medical evidence. However, this does not mean I can disregard it. I note Dr. McKnight's remark that the Claimant's description of his time at Dartmouth General Hospital did not correspond to what was in the hospital's records.[42] Again, in the circumstances, I prefer to rely on objective records.

[32] I also disagree with the Claimant's suggestion that he was not responsible for finding a capable doctor to report on his condition.[43] The burden of proof is on the Claimant. He must prove his case on a balance of probabilities. The Minister is not obligated to prove his case for him.

[33] Finally, in January 2020, the Claimant alleged that the Minister's prior decisions were examples of discrimination because of his ethnic and religious background.[44] However, in a March 2020 telephone call, he told a Tribunal officer that he did not want to advance arguments about a possible *Charter* violation. He also did not advance this argument at the hearing.

Did the Claimant have a prolonged disability by December 31, 2013?

[34] As the Claimant did not have a severe disability continuously from December 31, 2013, to his 65th birthday, I do not need to answer this question.

CONCLUSION

[35] The appeal is dismissed.

Pierre Vanderhout
Member, General Division - Income Security

[42] GD2-181 to GD2-182
[43] GD2-166
[44] GD1-8