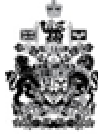

Citation: *NY v Minister of Employment and Social Development*, 2022 SST 95

Social Security Tribunal of Canada
Appeal Division

Decision

Appellant:	N. Y.
Representative:	Chantelle Yang (counsel)
Respondent:	Minister of Employment and Social Development
Representative:	Jessica Grant (counsel)

Decision under appeal:	General Division decision dated July 2, 2021 (GP-20-588)

Tribunal member:	Janet Lew
Type of hearing:	Teleconference
Hearing date:	December 2, 2021
Hearing participants:	Appellant's representative Respondent's representative
Decision date:	February 21, 2022
File number:	AD-21-317

Decision

[1] I am allowing the appeal. The Claimant is entitled to a Canada Pension Plan disability pension because she has had a severe and prolonged disability since the end of the minimum qualifying period on December 31, 2001. Payment of a pension starts as of August 2017.

Overview

[2] The Applicant, N. Y. (Claimant), is appealing the General Division decision. The General Division found that the Claimant did not have a severe disability. For that reason, it concluded that she was not eligible for a Canada Pension Plan disability pension.

[3] The Claimant argues that the General Division failed to consider her medical conditions on a cumulative basis. She argues that, had the General Division considered her medical conditions on a cumulative basis, it would have concluded that she had a severe disability by the end of her minimum qualifying period of December 31, 2001 (MQP).[1] She asks the Appeal Division to allow her appeal and grant her a disability pension.

[4] The Respondent, the Minister of Employment and Social Development (Minister) asks the Appeal Division to dismiss the appeal, irrespective of whether the Appeal Division finds that the General Division made an error.

Issue

[5] The only issue is whether the General Division failed to consider the Claimant's medical conditions on a cumulative basis.

---

[1] Service Canada uses a claimant's years of Canada Pension Plan contributions to calculate their coverage period, or "minimum qualifying period" (MQP). The end of the coverage period is called the MQP date. To qualify for a disability pension, a claimant has to have a severe and prolonged disability the end of their MQP. See section 44(2) of the *Canada Pension Plan*.

Analysis

[6] The Appeal Division may intervene in General Division decisions if there are jurisdictional, procedural, legal, or certain types of factual errors.[2]

Did the General Division fail to consider the Claimant's medical conditions on a cumulative basis?

[7] The Claimant argues that the General Division failed to consider the Claimant's medical conditions on a cumulative basis. The Minister argues that the General Division appropriately considered the Claimant's medical conditions on a cumulative basis.

[8] The General Division examined the Claimant's medical conditions, including:

- Depression and mood symptoms
- Bilateral leg weakness, wrist and back spasms
- Multiple sclerosis (MS) and
- Cognitive issues

[9] The Claimant says that the General Division was required to consider these medical conditions collectively.

[10] For ease of reference to the General Division decision, I will use the same subheadings as the General Division.

Depression and mood symptoms

[11] Of these, the General Division determined that the depression and mood symptoms were not present by the end of the Claimant's MQP. However, I note that,

[2] See section 58(1) of the *Department of Employment and Social Development Act*.

while the Claimant did not have a major psychiatric disorder, a psychiatrist found her distressed, which led to feelings of frustration, sadness, and anxiety.[3]

Multiple sclerosis

[12] On its face, it seems that the General Division rejected the Claimant's assertions that she has MS. The General Division wrote, "The medical evidence supports that she has MS. I do dispute this."[4]

[13] The General Division noted that Dr. Myles, a neurologist, "found [the Claimant's] history was suggestive of MS but there were insufficient abnormalities to confirm a definite diagnosis."[5] By citing the passage, the General Division suggested that it was not wholly convinced that the Claimant had MS.

[14] However, the General Division's "dispute" seems to be a typographical error. The General Division member likely meant to write, "I do not dispute this." The balance of the decision suggests that the General Division accepted that the Claimant has MS.

[15] The General Division noted that Dr. Myles was of the opinion that the Claimant's MS "had been relatively inactive with relapses separated by three and a half years."[6] The General Division seemed to accept that this meant Dr. Myles was prepared to accept that the Claimant had MS. The General Division concluded its analysis by writing, "While there may be periods of remission, I do not accept the Minister's refusal based on a period of remission for a disease which is a relapsing-remitting disease."[7]

[16] The General Division also noted the opinion of Dr. Roberts, a neurologist who the Claimant saw in 1992, 1998, and again in 1999. Dr. Roberts was of the opinion that the Claimant's MS was "well documented as definite."[8]

---

[3] See psychiatrist's opinion of November 4, 1999, at GD2-305 to 311 (and incomplete copies at GD2-180 to 185 and GD2-401 to 406).
[4] See General Division decision, at para 22.
[5] See neurologist's opinion dated June 20, 2001, at GD2-175 to GD2-176 (and at GD2-328 to 329, GD2-360 to 365 and GD2-411 to 412).
[6] See General Division decision
[7] See General Division decision at para 25.
[8] See neurologist's report of March 4, 1998, at GD2-177.

[17] Then, under its “The cognitive issues” section, the General Division member said that she accepted Dr. Roberts’s explanation that the Claimant’s memory and cognitive issues are a symptom of MS. In other words, if the memory and cognitive issues were symptoms of MS, then the General Division had to have accepted that the Claimant has MS.

[18] The General Division seemed to accept that, while the Claimant had MS, she had virtually no residual disability in 2001. This was because Dr. Myles found that, at the time of assessment in June 2001, there was virtually no residual disability and the disease had been relatively inactive with relapses separated by three and a half years.

Bilateral leg weakness, wrist and back spasms

[19] The Claimant accepted that the Claimant had some bilateral leg weakness, wrist dysfunction, back spasms, and cognitive issue. However, the General Division found that the evidence regarding the Claimant’s leg weakness and pain did not support a severe disability that would prevent her from working. The General Division found that:

- the Claimant did not mention any bilateral leg weakness in her 2001 application for disability benefits
- her family physician did not indicate that she required any treatments or specialist interventions for her legs or back
- she took Baclofen for only one month to deal with her leg issues
- the Claimant was able to continue driving
- Dr. Myles indicated the Claimant did not have any physical disabilities in 2001. (In fact, Dr. Myles noted that the Claimant reported several physical symptoms, including left lower extremity pain radiating from the ankle into the leg and hip and mild imbalance.)

[20] The General Division found that the Claimant had not stopped working in 1999 because of any limitations involving her legs, back, or wrists. She stopped working because of cognitive issues.

Cognitive issues

[21] The General Division found that the medical evidence supported a mild cognitive impairment in 1999 and in 2018. The General Division seemed to suggest that her cognitive impairment must have been mild since 1999.

Cumulative assessment of medical conditions

[22] In summary, the General Division found that the Claimant had MS, mild cognitive impairment, bilateral leg weakness, wrist dysfunction, and back spasms by the end of the Claimant's MQP. The General Division found that these conditions were not severe. The General Division found that the Claimant's depression and mood symptoms arose after the MQP had ended.

[23] The Claimant does not challenge the General Division's findings that her depression and mood symptoms arose after the MQP had ended. The Claimant does not challenge the General Division's findings that she had MS, mild cognitive impairment, and other medical issues by the end of her MQP. But, she says that the General Division did not consider these medical issues on a cumulative basis. She argues that, had the General Division considered her medical issues cumulatively, it would have determined that she has a severe disability.

[24] The Minister argues that the General Division did not have to write that it considered the Claimant's conditions on a cumulative basis, or words to that effect, as long as it actually considered the Claimant's medical conditions cumulatively.

[25] The Minister argues that it is evident from paragraphs 8, 40, and 41 of the General Division decision that it considered all of the Claimant's medical issues cumulatively.

[26] Paragraph 8 reads as follows:

> The Claimant had MS and cognitive issues at the time of her MQP. My focus though is not on the Claimant's diagnosis.[9] I must focus on whether she had functional limitations that got in the way of her earning a living.[10] This means I have to look at **all** the Claimant's medical conditions (not just the main one) and think about how her conditions affect her ability to work.[11]

[27] Paragraphs 40 and 41 read as follows:

> The medical evidence does not show that the Claimant has functional limitations that affected her ability to work at any occupation by December 31, 2001. As a result, she has not proven that she had a severe disability.
>
> When I am deciding if a disability is severe, I sometimes have to think about a person's age, level of education, language ability, and past work and life experience. This allows a realistic assessment of their work capacity. I don't have to do that here because the Claimant's functional limitations did not affect her ability to work by December 13, 2001. This means she did not prove her disability was severe by then.

[28] Paragraph 8 falls short of showing any cumulative assessment of the Claimant's medical conditions. The General Division said that it was obligated to assess all of the Claimant's medical conditions, and not just the primary ones.

[29] While the General Division clearly assessed each of the Claimant's conditions, and not just her primary complaints, the General Division also had to consider the overall impact that the Claimant's conditions had on her collectively. The General Division did not say that it also assessed all of the medical conditions together.

[30] Paragraphs 40 and 41 are more suggestive of a cumulative assessment. One can usually infer that the General Division considered the conditions cumulatively if the member considered whether a claimant had functional limitations and the overall impact that they had on their ability to regularly pursue any substantially gainful occupation.

---

[9] The Federal Court of Appeal said this in *Ferreira v Canada (Attorney General)*, 2013 FCA 81.
[10] The Federal Court of Appeal said this in *Klabouch v Canada (Attorney General)*, 2008 FCA 33.
[11] The Federal Court of Appeal said this in *Bungay v Canada (Attorney General)*, 2011 FCA 47.

[31] However, there is no analysis as to what those functional limitations were and how they affected the Claimant's employability on a cumulative basis. Without such an analysis, it is unclear whether the General Division considered how the cumulative impacts of the Claimant's physical, mental, and cognitive conditions had on her functionality and employability.

[32] The General Division had to consider the Claimant's MS, cognitive impairment, bilateral leg weakness, wrist dysfunction, and back spasms as a collective, not on a piece-meal basis. It is not apparent that it did so.

[33] On top of this, it is clear from the 1999 psychiatrist's opinion that the Claimant had mood-related issues. She felt distressed, which led to feelings of frustration, sadness, and anxiety. The psychiatrist wrote that these symptoms were within keeping of a normal response for her circumstance.[12]

[34] Notably, the psychiatrist was also of the opinion that, with MS, the Claimant could see fluctuations in her mood and anxiety levels. The psychiatrist was also of the opinion that the Claimant was at risk for depression if her cognitive symptoms did not improve and she was unable to return to work.

[35] Dr. Roberts believed that neuropsychological testing would be beneficial. It would help determine the level of the Claimant's mental dysfunction and perhaps give further insight into unrecognized depressive features of her illness.[13]

[36] While the Claimant had not been diagnosed with a major psychiatric disorder and her symptoms were "within keeping of a normal response for her circumstance",[14] that does not mean that her mood-related symptoms could not have had some measure of impact on the Claimant's functionality by the end of her MQP.

[37] Setting aside the Claimant's mood-related issues, including anxiety and possible fluctuations in her mood and anxiety levels, the General Division still had to consider the

---

[12] See psychiatrist's opinion of November 4, 1999, at GD2-306.
[13] See neurologist's opinion of November 29, 1999, at GD2-314 to GD2-316.
[14] See psychiatrist's opinion of November 4, 1999, at GD2-306.

Claimant's other medical issues together. Although the General Division focused on the Claimant's MS, cognitive impairment, bilateral leg weakness, wrist dysfunction, and back spasms, the Claimant had reported other symptoms to Dr. Myles.

[38] For instance, Dr. Myles noted that the Claimant had a worsening of vision. The loss of vision started at about the beginning of 2001 and showed no signs of improvement. Dr. Myles described the vision loss as a distinct symptom. The Claimant also reported, "marked fatigue", amongst other symptoms.

[39] For instance, while some days were good, the Claimant she had a lot of problems with her eyes. They would go fuzzy one eye at a time. She said that she lost most of the vision in her left eye.[15]

[40] Yet, the General Division did not refer to any of these other medical issues nor to any of this evidence. It is unclear whether the General Division overlooked or dismissed these complaints. If the latter, it did not explain why it dismissed them.

[41] These medical conditions merited consideration because they could have had considerable impact on the Claimant's functionality and employability. They should have formed part of the General Division's cumulative analysis.

[42] I am satisfied that the General Division failed to conduct a cumulative assessment of the Claimant`s conditions and their impact on her employability. This included symptoms that the Claimant reported in 2001 that the General Division did not seem to consider.

Remedy

[43] How can I fix the General Division's error? I have two basic choices.[16] I can substitute my own decision or I can refer the matter back to the General Division for

---

[15] See Claimant's questionnaire dated July 19, 2001, at GD2-447 to GD2-453.
[16] Section 59 of the *Department of Employment and Social Development Act*.

reconsideration. If I substitute my own decision, this means I may make findings of fact.[17]

[44] Neither the Claimant nor the Minister have asked me to return this matter to the General Division for a reconsideration. There is little to gain by returning this matter to the General Division. The Claimant's minimum qualifying period is in the distant past. More than 10 years has passed since the end of the Claimant's minimum qualifying period.

[45] The Claimant had a fair hearing. She was aware of the case she had to meet. She had the chance to produce any witnesses. There is no suggestion that there are any gaps in the evidence, or that there is a need to clarify any of the evidence. The parties have produced all of the relevant records.

[46] Given these considerations, I find it appropriate to review this matter and come to my own decision.

– The Parties' arguments

[47] The Claimant asks me to give the decision that she says the General Division should have given. She says the General Division should have found that she had a severe and prolonged disability by the end of her MQP on December 31, 2001, and that it has been continuous since then.

[48] The Minister argues that, even if the General Division made any errors, it does not change the outcome because the evidence does not establish that the Claimant had a severe and prolonged disability by December 31, 2001.

Substituting my own decision

[49] The Minister recognizes that the Claimant is currently severely disabled. However, the Minister says that none of the medical evidence shows that the Claimant

---

[17] *Weatherley v Canada (Attorney General)*, 2021 FCA 58, at paras 49 and 53, and *Nelson v Canada (Attorney General)*, 2019 FCA 222, at para 17.

had a severe disability by the end of her minimum qualifying period. I have come to a different conclusion.

[50] The Minister relies on the opinion from the neurologist Dr. Myles. She wrote that, if the Claimant did in fact have MS, “her disease has been relatively inactive with relapses separated by three and one-half years...” [18] In other words, Dr. Myles was suggesting that the Claimant’s condition could not have been that severe. Indeed, Dr. Myles found that there was “virtually no residual disability.”[19]

[51] The Minister also relies on the family doctor’s opinion. The family doctor completed a form on February 27, 2002 for the Claimant’s disability insurer.[20] This was two months after the end of the MQP. The doctor saw the Claimant that day.

[52] The form contains two questions about the Claimant’s suitability for trial employment. The questions read:

> 12. Is the patient a suitable candidate for trial employment?
>
> For his/her occupation ◻ Yes ☒ No
>
> For any other work ☒ Yes ◻ No
>
> Please provide comments or further details that you feel are relevant to the ability of the patient to return to work.

[53] The family doctor responded that the Claimant was not suitable for trial employment in her occupation. But, he found her suitable for any other work, with “restrictions physically + mentally.”[21] The doctor did not describe these restrictions.

---

[18] See Dr. Myles’s report of June 20, 2001, at GD2-175 to GD2-176 (and at GD2-328 to 329, GD2-360 to 365 and GD2-411 to 412).
[19] See Dr. Myles’ report of June 20, 2001, at GD2-175 to GD2-176 (and at GD2-328 to 329, GD2-360 to 365 and GD2-411 to 412).
[20] See family doctor’s statement dated February 27, 2002, at GD2-299 to 300.
[21] See Attending Physician Supplementary Statement dated February 27, 2002, at GD2-299 to GD2-300.

[54] The Minister says that the Claimant had to show that she was unable to work because of her medical condition. But, the Minister argues that, where evidence such as the family doctor's report shows that the Claimant still had the capacity for some work, the law required her to find work suitable to her condition.

[55] The Minister acknowledged that the Claimant was fearful that any new employer would find out that she has MS and that this would lead to dismissal. But, the Minister says her fears did not excuse her from having to look for work suitable to her condition.

[56] In short, the Minister submits that the Claimant did not fulfill all of the requirements to be eligible for a Canada Pension Plan disability.

[57] I will examine the most salient medical records. The two medical reports that the Minister relies on are among those closest to the end of the minimum qualifying period. For that reason, they would ordinarily carry a lot of weight.

– **Neurologist's opinion of June 20, 2001 that the Claimant had "virtually no residual disability" was inaccurate**

[58] Dr. Myles was of the opinion that the Claimant had virtually no residual disability when she saw her in mid-2001. And, if the Claimant had MS, it was relatively inactive with relapses separated by 3.5 years. However, there are two glaring weaknesses in Dr. Myles's opinion:

i. Dr. Myles did not have a full medical picture and

ii. Dr. Myles's conclusions were inconsistent with the medical records and with the history that she obtained from the Claimant.

[59] I will comment on each of these.

○ **Dr. Myles did not have a full medical picture**

[60] Dr. Myles found that there was insufficient objective abnormalities, so was unprepared to confirm a diagnosis of MS, despite the Claimant's clinical history. Dr. Myles only went so far as to suggest that the history suggested MS.

[61] The lack of “objective abnormalities” seemed to colour Dr. Myles’s views of the extent of the Claimant’s disability. Yet, she did not have a full medical picture.

[62] If Dr. Myles had a copy of the available records, she might have been able to confirm that the Claimant had MS and that she was experiencing limitations.

[63] Dr. Myles indicated that she did not have a copy of any MRI results. The MRI taken in September 1992 showed lesions in the brain. The radiologist found this typical of demyelinating disease.[22] If Dr. Myles had had a copy of this MRI of the Claimant’s brain at that time, likely she would have had to accept that the Claimant has MS. The Claimant`s clinical presentation also supported such a diagnosis.

[64] There was a CT scan, taken on November 16, 1999. Dr. Myles was also unaware of the findings of the CT scan.

[65] The radiologist wrote that the results showed bilateral frontal and temporal lobe moderate atrophy.[23] The radiologist did not explain the significance of these findings, but they could account for the Claimant’s poorer cognitive functioning.

[66] Much like the 1992 MRI of the brain, a more recent one, taken in December 2018, also showed multiple lesions. The radiologist confirmed that the multiple lesions were consistent with a clinical history of MS.[24]

[67] Indeed, in a subsequent letter dated August 28, 2007, it is clear that, at some point, Dr. Myles received a copy of the 1992 MRI. It was then that she was prepared to accept that the Claimant had MS.[25]

- **Dr. Myles’s conclusions were inconsistent with the records and the Claimant’s history**

[68] Dr. Myles concluded that, if indeed the Claimant had MS, it had been relatively inactive in the past 3.5 years and that there was virtually no residual disability. Yet, her

[22] See MRI dated September 18, 1992, at GD2-337 and GD2-353.
[23] See CT scan of head, dated November 16, 1999, at GD2-317.
[24] See MRI of December 18, 2018, at GD2-156 and GD2-172.
[25] See Dr. Myles’s letter dated August 28, 2007, at GD2-325.

conclusion was inconsistent with the history that she obtained from the Claimant. It was also inconsistent with the medical records.

[69] The Claimant described her symptoms to Dr. Myles. The Claimant reported cognitive dysfunction (including short-term memory issues), pains, marked fatigue, back spasms, bladder function and balance issues. She also had worsening vision in the past six months. Dr. Myles noted these complaints.

[70] Dr. Myles also noted that the Claimant had trouble pinpointing when her symptoms began. Dr. Myles decided that there was a 3.5-year timeframe of relatively inactive MS. This coincides with the time that the Claimant developed decreased vision and facial numbness.

[71] However, the Claimant saw Dr. Roberts again after her vision loss in December 1997. Her family doctor referred her to see Dr. Roberts again in August 1999. This time, it was for an assessment of memory loss and decreased mental abilities. The Claimant also reported facial numbness and blurred vision.

[72] When the Claimant saw Dr. Roberts again in August 1999, she described how she had been making mistakes at work for at least the past year. She worked for a financial institution. The employer had significant concerns over several performance areas. She had repeated errors, which was uncharacteristic. The employer asked her to assess her mental abilities and to go on short- and long-term disability. [26] The Claimant understood that her employer asked her to resign.[27]

[73] Dr. Roberts stated in his report that he would conduct more investigations. He suggested that, if tests were negative, that the family doctor pursue a psychological assessment. This would allow for formal assessment of the Claimant's memory.

[26] See employer's inter-office memorandum dated July 14, 1999, at GD2-213.
[27] See neurologist's consultation report, dated August 20, 1999, at GD2-293.

[74] The Claimant's family doctor prepared a report dated August 20, 1999. He wrote that the Claimant had "memory loss and easy confusion."[28] He diagnosed her with MS and mild dementia, secondary to demyelination associated with MS.

[75] In November 1999, the Claimant saw a psychiatrist, at the request of her disability insurer. The psychiatrist also identified cognitive impairment.[29] The Claimant gave a history of decreased concentration and difficulty with short-term memory.

[76] In March 2000, the family physician wrote to the insurer, indicating that follow-up with a neurologist would benefit the Claimant.[30] The family physician referred to Dr. Roberts's management suggestions. It is unclear what these suggestions might have been, apart possibly from a neuropsychological assessment. Dr. Roberts does not appear to have made any other treatment recommendations.[31] He does not appear to have seen the Claimant again after 1999.

[77] In February 2001, the family physician prepared another statement. He described the Claimant's symptoms. The Claimant had "low energy; mild/moderate cognitive impairment; increasing weakness of lower extremities."[32] The prognosis was "stabilization with continuing impairment." The doctor was of the view that the Claimant could not perform the cognitive functions of her last job, or perform any physically or mentally demanding duties.

[78] The family physician prepared a Canada Pension Plan medical report in July 2001. He reported that the Claimant experienced weakness, fatigue, and cognitive impairment.[33]

---

[28] See family physician's statement, dated August 20, 1999, at GD2-287.
[29] See psychiatrist's opinion of November 4, 1999, at GD2-306.
[30] See family physician's letter dated March 16, 2000, to disability insurer, at GD2-318.
[31] See neurologist's report of August 20, 1999, at GD2-294, and response of November 29, 1999, to disability insurer, at GD2-314 to GD2-316.
[32] See family physician's statement, dated February 24, 2001, at GD2-301 to GD2-303.
[33] See Canada Pension Plan medical report dated July 3, 2001, at GD2-436 to 439.

[79] The Claimant applied for a disability pension in July 2001.[34] She wrote in the accompanying questionnaire that she had stopped working in 1999 because of problems with her memory, concentration, vision, and fatigue. She got confused and easily frustrated. Sometimes, it was difficult to carry on a conversation. She would mix up words. She also found that her physical strength came and went. Some days were good, while others were not.[35]

[80] The Canada Pension Plan medical report from the Claimant's family physician indicates that the Claimant had weakness, fatigue, and cognitive impairment.[36]

[81] In January 2002, the Claimant asked the Minister to reconsider her application for disability benefits.[37] This was not long after the minimum qualifying period had ended. The Claimant described how she was feeling at that particular time:

- She was having problems walking and standing. Baclofen brought relief of the throbbing pain, but she still had constant stabbing pain. Day to day, she did not know how long her leg would hold up. One time, her left leg would not move. She had to cling onto a shelf for support.

- Fatigue.

- Her vision came and went, so she had frequent headaches. Because of her vision, she had problems reading. She became "very tired" when she did read.

  Changes in temperature (e.g. taking a hot shower) could lead to her vision going black, feeling weak and falling.

- She had weakness in her arms, so it could take a long time to do things, such as wash her hair.

---

[34] The Claimant has made four applications for a disability pension: July 2001, November 2003, August 2007, and most recently, on July 25, 2018. The Minister has rejected each of her applications.
[35] See questionnaire dated July 19, 2001, at GD2-447 to GD2-453.
[36] See Canada Pension Plan medical report dated July 3, 2001, at GD2-436 to GD2-439.
[37] See Claimant's letter dated January 15, 2002, at GD2-95 to GD2-96.

- Memory issues.

[82] Finally, in the Canada Pension Plan medical report of November 2003, the family physician reported that the Claimant's MS had been inactive until 1999. In other words, it had been active since then.[38]

[83] It is clear from the medical records from 1999 to 2001 that it was inaccurate to say that the Claimant had "virtually no residual disability" or that her MS was "relatively inactive" between 1997 and mid-2001.

[84] The evidence overwhelmingly shows that the Claimant's MS was active. The evidence also shows that the Claimant experienced symptoms of MS at the end of her minimum qualifying period. The symptoms included vision impairment, cognitive impairment including memory loss and easy confusion, balance issues, marked fatigue, sleep disturbance, increasing weakness of lower extremities, and pain. As the Claimant indicated in her January 2002 letter, her condition was unpredictable one moment from the next.

[85] Usually one would rely on a report like Dr. Myles's because she prepared it close to the end of the Claimant's minimum qualifying period. However, her conclusions that the Claimant had virtually no residual disability and that her MS was relatively inactive are inconsistent with the records and the history the Claimant gave her. For that reason, I find her report an unreliable measure of the severity of the Claimant's disability.

[86] Because Dr. Myles's report is unreliable, little weight or consideration should be given to it when determining whether the Claimant was severely disabled by the end of her MQP. I do not accept her conclusions that the Claimant's MS had been relatively inactive in the past 3.5 years and that there was virtually no residual disability in mid-2001.

---

[38] See Canada Pension Plan medical report dated November 17, 2003, at GD2-390.

– **Doctors agree that the Claimant`s cognitive impairment made her unsuitable for her past employment**

[87] The doctors agree that the Claimant's condition made her unfit for part-time or full-time at her former job as a loan administrator.[39] The psychiatrist was of the opinion that:

> [The Claimant's] cognitive deficits would prevent her from functioning appropriately. What is also problematic is the fact that she does not have insight into the errors that she is making. The errors will result in difficulties for customers and the bank. Also, putting her in a workplace where she will make these errors could cost her her job. In other words, no one would benefit from her being in the workplace with her present deficits. The specific factors that affect her at the present time include trouble with her memory, trouble with decision-making, and trouble with her cognitive functioning. Both verbal and mathematical skills seem to be affected.[40]

[88] The Claimant's symptoms clearly had some impact on her past work. Indeed, the Claimant's cognitive impairment—her memory, decision-making, concentration, and confused state--cost her her employment as a loan administrator.

[89] The Claimant was clearly unsuitable for her past employment. But, for the purposes of meeting the disability requirements under the *Canada Pension Plan*, the Claimant had to be incapable regularly of pursuing any substantially gainful occupation, not just her past employment. Or, as the Federal Court of Appeal put it, her disability had to prevent her from earning a living.[41]

[90] Dr. Roberts and the psychiatrist focussed on the Claimant's suitability for part- or full-time work as a loan administrator. Neither Dr. Roberts nor the psychiatrist specifically addressed whether the Claimant could pursue other employment opportunities within her capabilities.

---

[39] See psychiatrist's opinion of November 4, 1999, at GD2-305. See also neurologist's opinion of November 29, 1999, at GD2-315 and family doctor's reports, including statement, dated February 27, 2002, at GD2-300.

[40] See psychiatrist's opinion of November 4, 1999, at GD2-310.

[41] See *Berger v Canada (Attorney General)*, 2022 FCA 4 at para 22.

– **Family physician was of the opinion that the Claimant could do other work**

[91] In his medical report of July 3, 2001, the family doctor indicated that he had last seen the Claimant in May 2001. He wrote that the office examination had been normal. While she had limitations, such as weakness, fatigue, and cognitive impairment, he was of the opinion that she "was doing well @ present."[42]

[92] The family physician did not note all of the symptoms, such as vision loss, that the Claimant was experiencing. More importantly, he did not explain why he believed that the Claimant was doing well if she experienced weakness and fatigue, as well as cognitive impairment.

[93] The family physician prepared a report two months after the end of the minimum qualifying period. He was of the opinion that, while the Claimant had unspecified physical and mental restrictions, she was suitable for other work.[43] He did not say what other work he thought she could perform, what limitations she faced, or whether she would require any accommodations, if any.

– **What a severe disability is under the Canada Pension Plan**

[94] The Claimant's family physician stated that the Claimant could do work other than as a loan administrator. However, the test for disability under the *Canada Pension Plan* is not whether a claimant is suitable for any other work. While there is a component of employability to the test, that employment has to be substantially gainful. That is, is a claimant must be able to earn a living from this other employment.[44]

[95] Further, there is an aspect of regularity to the disability test. Under subparagraph 42(2)(*a*)(i) of the *Canada Pension Plan*, a person is determined to have a severe disability if they are "incapable regularly of pursuing any substantially gainful occupation."

[42] See family physician's Canada Pension Plan medical report dated July 3, 2001, at GD2-439.
[43] See Attending Physician Supplementary Statement dated February 27, 2002, at GD2-299 to GD2-300.
[44] See *Berger*, at para 22.

[96] As the Federal Court of Appeal held in a case called *Villani*,[45] each word in subparagraph 42(2)(*a*)(i) of the *Canada Pension Plan* must be given meaning. When read in that way, an applicant is severely disabled if they are “incapable of pursuing with consistent frequency any truly remunerative occupation.”[46]

[97] In a case called *Atkinson*,[47] the Court of Appeal noted that predictability is the essence of regularity. This was a view endorsed in other cases, including *Balkanyi*[48] and *Riccio.*[49] In *Riccio,* t*he* Court of Appeal held that “regularly” reflects the reality that employees, even part-time ones, “are expected to attend work on the dates and times they are scheduled to do so.”[50]

[98] In addition, when considering the hypothetical occupations for which a claimant is considered suitable, one also has to think about their particular circumstances. This includes considering things such as age, education level, language proficiency and past work and life experience.[51] This is the “*Villani”* test.

– **The Claimant’s medical conditions and circumstances**

[99] The medical evidence leading up to the end of the minimum qualifying period shows the following:

- Over several months in 1992, the Claimant experienced weakness in her right hand and sensory disturbance in her left leg. An MRI showed lesions. Dr. Roberts diagnosed the Claimant with demyelinating disease.

[45] See *Villani v Canada (Attorney General),* 2001 FCA 248.
[46] See *Villani* at para 38.
[47] See *Atkinson v Canada (Attorney General)*, 2014 FCA 187 at para 38, referring to *Canada (Minister of Human Resources Development) v Scott*, 2003 FCA 34.
[48] See *Balkanyi v Canada (Attorney General)*, 2021 FCA 164.
[49] See *Riccio v Canada (Attorney General)*, 2 021 FCA 108.
[50] See *Riccio,* at para 23.
[51] See *Villani*, at paras 38 and 39.

- In late 1997 and into 1998, the Claimant had vision loss in her left eye, leaving her unable to read. She also experienced increased fatigue and slightly impaired balance.[52]

- By mid-1999, the Claimant began experiencing memory loss and easy confusion. She had decreased mental abilities and blurred vision. Her family doctor also diagnosed her with mild dementia. She had been making mistakes at work. She reported that her employer had asked her to resign and undergo assessments for her mental abilities. Dr. Roberts later described these symptoms as a global loss of mental function in part related to MS.[53] In September 1999, Dr. Roberts diagnosed her with hypothyroidism.[54]

- In November 1999, the Claimant saw a psychiatrist at her insurer's request. She had been having problems with her memory, making decisions, and following routine procedures. She was unware of the cognitive difficulties that led to errors. Others, including customers, observed her deficits.[55] The psychiatrist noted that both verbal and mathematical skills were affected. He was of the view that the Claimant was likely to develop secondary depression.

- In 2000, the Claimant's family physician agreed that follow-up with a specialist would be beneficial for the Claimant.[56] He mistakenly believed that the Claimant was continuing to see a neurologist.

- In early 2001, the family physician noted the Claimant's low energy, mild/moderate cognitive impairment and increasing weakness in her lower extremities. The Claimant was not returning to work, pending resolution of her cognitive dysfunction. The family physician determined that she was unable to perform physically or mentally demanding duties.[57] The family physician was of

[52] See consultation reports of eye doctor and neurologist, dated January 29, 1998 and March 4, 1998, at GD2-179 and GD2-177.
[53] See neurologist's opinion dated December 18, 2001, at GD2-289.
[54] See consultation report of neurologist dated September 3, 1999, at GD2-292.
[55] See psychiatrist's opinion of November 4, 1999, at GD2-306.
[56] See family doctor's letter dated March 16, 2000, to the Claimant's disability insurer, at GD 2-206.
[57] See physician's statement to disability insurer, dated February 24, 2001, at GD2-302 to GD2-303.

the opinion that typically she could expect a progressive loss of function but was doing well at that time.[58]

- The Claimant saw Dr. Myles in mid-2001. The Claimant reported that she had worsening vision for the past six months, with no improvement. The Claimant also reported problems with short-term memory, marked fatigue, left lower extremity pain radiating from the ankle into the leg and hip, mild imbalance, back spasms, and sleep disturbance. Without having seen the diagnostic examinations, Dr. Myles was unprepared to confirm the diagnosis of MS, though it appeared to her that the Claimant had relapsing-remitting disease.[59]

  Dr. Myles recommended an exercise program to improve sleep and pain, but as she found the Claimant did not have any residual disability, said the Claimant did not qualify for immunomodulatory therapy.

  However, Dr. Myles was wrong to conclude that the Claimant did not have any residual disability, when the Claimant reported that she was experiencing several symptoms of MS.

- In December 2001, the Claimant had x-rays of her pelvis, left hip, left knee, left ankle, and lower back. There was narrowing at the L5-S1 region and osteophytic lipping at L3-4 and L2-3. The disc narrowing and osteophytic lipping could account for the Claimant's back pain.

[100] When the Claimant applied for Canada Pension Plan disability benefits, she explained why she had stopped working. She had problems with her memory, constant fatigue, inability to concentrate, and problems with her eyesight.[60] She noted that she got confused and easily frustrated. Sometimes, it was difficult to carry on a conversation. She would mix up words. She also found that her physical strength came

---

[58] See family physician's Canada Pension Plan medical report dated July 3, 2001, at GD2-439.
[59] See Dr. Myles' report of June 20, 2001, at GD2-175 to GD2-176 (and at GD2-328 to 329, GD2-360 to 365 and GD2-411 to 412).
[60] See questionnaire dated July 19, 2001, at GD2-447.

and went. Some days were good, while others were not.[61] She complained of back spasms and dizzy spells.

[101] When the Minister denied her application, the Claimant asked the Minister to reconsider.[62] She noted that her vision came and went, so she had frequent headaches. She had problems reading, which fatigued her. She questioned how anyone could expect her to do any type of work on a regular basis, when she could not predict how she would be one day from the next. She did not know when her leg would hold up, without giving out, or when she would need to rest.

[102] The Claimant noted that even her employer, a diversified financial services group, was unprepared or unwilling to offer her any alternative employment, even though she had been with the company for over 20 years and had been a highly regarded employee, until her medical issues arose.

– **The Claimant's disability has been and continues to be severe**

[103] The Claimant was 41 years of age at the end of her minimum qualifying period. She has a high school education. She has worked in just the financial sector and worked for only one employer. (Her initial employer amalgamated with another financial institution.). She started working as a mail clerk and then moved up to the position of mortgage secretary. Then, she began working as a loan administrator. She held this position for about 15 months when her employer asked her to go on short-term disability and seek medical attention. The Claimant has not worked since.

[104] Taking these factors into account, the Claimant's education and work experience limited the hypothetical occupations for which the Claimant was suited.

[105] Clearly, the Claimant was unsuited for anything for which she was educated or had any work experience. This was primarily because of her vision loss and cognitive impairment, which she claims left her easily confused and, at times, unable to read. Her cognitive impairment also affected her short-term memory and her ability to follow

---

[61] See questionnaire dated July 19, 2001, at GD2-447 to GD2-453.
[62] See Claimant's letter dated January 15, 2002, at GD2-95 to GD2-96

routine procedures. It is evident that the Claimant would have been unable to do any clerical, administrative, or office duties.

[106] The Claimant's family physician believed that the Claimant was doing well in 2001, and that, in early 2002, she was suitable for other work, with physical and mental restrictions.

[107] However, the Claimant's medical records for 2001 and into early 2002 show that the Claimant could not be expected to pursue with consistent frequency any truly remunerative occupation. While she had some good days, her condition was overall unpredictable. The Claimant had both physical and cognitive issues. This included vision loss, weakness in her extremities, imbalance, fatigue, and cognitive issues. Her condition fluctuated from day to day, and from month to month.

[108] The Claimant's conditions—viewed separately—may not have been severe by the end of 2001, but taken together, along with their unpredictable nature as to when they might occur, the Claimant was incapable regularly of pursuing a substantially gainful occupation.

[109] Her family physician suggested that she could have pursued other employment opportunities outside her field of work experience. However, this would have demanded a benevolent employer who would accommodate the unpredictable nature of her disability. She could not predict when she might lose her vision or her balance, let alone know whether she could rely on her cognitive abilities.

[110] The Claimant may have been able to attend work on most scheduled dates and times, but she would have been unable to regularly meet the demands of any occupation, even if they were not particularly physically or mentally demanding. The Claimant had both cognitive impairment – confusion, memory, verbal and mathematical deficits – as well as physical issues, such as vision loss and imbalance issues.

[111] There are two other issues to address: (1) compliance with treatment recommendations, and (2) normal test results.

- **Compliance with treatment recommendations**

[112] The medical records indicate that the Claimant was not pursuing much in the way of medical investigations or treatment in 2000 and 2001 for her MS. A lack of treatment ordinarily would suggest that one's medical condition is not that severe.

[113] However, Dr. Roberts did not provide any specific treatment recommendations for the Claimant's MS.[63] He did share the psychiatrist's opinion advice that neuropsychological testing would be beneficial. It would help determine the level of the Claimant's mental dysfunction and perhaps give further insight into unrecognized depressive features of her illness.

[114] However, it does not appear that either Dr. Roberts or psychiatrist communicated this recommendation to the Claimant. Neither the disability insurer nor the family physician arranged for any neuropsychological testing.

[115] Dr. Myles indicated that if she could confirm MS, she would have recommended immunomodulatory therapy (i.e. drug therapy). But, the family doctor found that there was no effective treatment available for MS.[64] He otherwise considered the Claimant compliant with treatment recommendations. In this regard, I note that the Claimant attended MS support groups monthly.[65] I find that she was compliant with the recommendations that she received.

- **Normal test results**

[116] The General Division suggested that the Claimant could not have had a severe disability if she had normal cognitive functioning in 2018.[66] The family physician also noted that the Claimant did not have any gross motor deficits either at that time.[67] The

[63] See neurologist's response of November 29, 1999, to disability insurer, at GD2-314 to GD2-316.
[64] See family physician's statement dated December 20, 2018, at GD2-155.
[65] See psychiatrist's opinion of November 4, 1999, at GD2-308.
[66] See General Division decision at paras 36 and 37, likely referring to the family physician's medical report dated December 27, 2018, at GD2-168.
[67] See family physician's medical report dated December 27, 2018, at GD2-168.

General Division seemed to suggest that the Claimant was exaggerating her condition or was not under any disability at that time.

[117] Yet, relying on test scores from a particular point in time fails to appreciate the remitting-relapsing nature of the Claimant's disease. It is clear from the overall clinical history and the medical evidence spanning several years that the Claimant's cognitive impairment is real. There is irrefutable objective medical evidence that the Claimant has multiple lesions in her brain, which confirms the MS and supports the clinical history.

[118] The fact that the Claimant may have been presentable in December 2018 did not diminish the severity of her disability. It was simply a reflection of the unpredictable nature of the disease. Indeed, the General Division member recognized this when she explained why she did not accept the Minister's refusal of the Claimant's application. The member stated that she did not accept the Minister's refusal because it was "based on a period of remission for a disease which is a relapsing-remitting disease."[68]

[119] I accept that the Claimant had and continues to have a severe disability since the end of her minimum qualifying period.

– **The Claimant's disability is prolonged**

[120] The evidence also shows that the Claimant's disability is prolonged. In July 2001 and again in November 2003, the family physician stated that, typically, the Claimant could expect a progressive loss of function.[69] This has been borne out.

[121] The Claimant's overall condition has deteriorated since the end of her minimum qualifying period. In November 2003, the family physician noted that the Claimant had seen a decline of cognitive function. In July 2004, the family physician documented a two-year exacerbation of symptoms. The Claimant's left leg weakness, for instance, had become constant, and she had a slight deterioration in her vision.[70]

---

[68] See General Division decision at para 25.
[69] See family physician's Canada Pension Plan medical report dated July 3, 2001, at GD2-439, and medical report dated November 17, 2003, at GD2-393.
[70] See family physician's statement to insurer, dated July 28, 2004, at GD2-322 to GD2-323.

[122] Even Dr. Myles commented that she expected that, if the Claimant had cognitive impairment, the disease would "have substantially increased over time," since 1992 when the Claimant "had a very mild burden of disease."[71]

[123] The Claimant's prognosis for recovery was "poor"[72] and "unfavourable".[73] The family physician was of the opinion that the Claimant's condition was unlikely to improve, as there was no effective treatment available for MS.[74]

– **Payment of a Canada Pension Plan disability pension**

[124] The Claimant filed four applications for a disability pension. She filed her first application in July 2001. However, her current appeal is in regards to her application of July 25, 2018. So, I must use the July 2018 application date to determine the Claimant's deemed date of disability.

[125] Based on the Claimant's application of July 25, 2018,[75] the earliest that the Claimant can be deemed disabled under section 42(2)(*b*) of the *Canada Pension Plan* is April 2017.

[126] With a deemed disability date of April 2017, a disability pension is payable four months later, starting in August 2017, under section 69 of the *Canada Pension Plan*.

Conclusion

[127] I am allowing the appeal. The Claimant is eligible for a Canada Pension Plan disability pension because her disability has been severe and prolonged since the end of her minimum qualifying period. Payment of a pension starts as of August 2017.

Janet Lew
Member, Appeal Division

---

[71] See Dr. Myles's letter dated August 28, 2007, at GD2-325.
[72] See family physician's statement dated June 23, 2003, at GD2-321.
[73] See family physician's statement dated July 28, 2004, at GD2-323.
[74] See family physician's statement dated December 29, 2018, at GD2-155.
[75] See Claimant's application of July 24, 2001, at GD2-102.