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Indexed as:
R.B.M. (Re)

IN THE MATTER OF an appeal by R.B.M.
AICAC File No.: AC-97-142

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[1998] M.A.I.C.A.C.D. No. 39

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Manitoba Automobile Injury Compensation Appeal Commission
J.F.R. Taylor, Q.C. (Chairperson), L. Goodspeed, and
F.L. Cox

Heard: November 12, 1998.
Decision: December 7, 1998.
(42 paras.)

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Issues(s):

Whether Appellant entitled to continued chiropractic
care.

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Relevant Sections:

Section 136(1) of the MPIC Act and Section 5 of Manitoba
Regulation No. 40/94.

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Appearances:

Manitoba Public Insurance Corporation ('MPIC') represented by
Joan McKelvey.

The appellant, R.B.M., appeared on his own behalf.

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MAIC NOTE: THIS DECISION HAS BEEN EDITED TO PROTECT THE
PERSONAL HEALTH INFORMATION OF INDIVIDUALS BY REMOVING
PERSONAL IDENTIFIERS AND OTHER IDENTIFYING INFORMATION.

REASONS FOR DECISION

THE ACCIDENT:

[para1] R.B.M., the Appellant, was involved in a motor
vehicle accident on September 22nd, 1994. A long distance
truck driver at the time, he was asleep in the sleeper section
of his vehicle that was being driven by one of his colleagues,
when the truck apparently ran into a ditch and flipped over.
He remembers being thrown about in the sleeper but then was

knocked out for some fifteen to twenty minutes, he believes. When he recovered consciousness he tried to get up but experienced severe thoracic back pain and some posterior neck pain. He had to be helped out of the vehicle and was taken to a satellite hospital of the Mayo Clinic at Rochester, Minnesota, where he was admitted for two and a half days. He was sent home from that hospital, utilizing a brace, but since he was unable to cope with that pain at his home he was subsequently admitted to the hospital in Steinbach, Manitoba, where he remained for some ten to twelve days. Ever since that time he has been receiving chiropractic treatments, directed towards his cervical and spinal areas.

POST-ACCIDENT MEDICAL/REHABILITATIVE HISTORY:

[para2] R.B.M., who was referred by his family physician, Dr. Gordon Dyck, to an orthopaedic specialist, Dr. D. Birt, was diagnosed by Dr. Birt as having sustained "stable compression fracture of the seventh thoracic and a minor degree of trauma causing fracture to perhaps T6 and T8. The transverse processes fractures on the left at T5 and T6 and on the right at the costovertebral junction at T5 and T6 also are very stable injuries". Dr. Birt offered the opinion that these injuries should not cause late arthritic change, that there was no compromise of R.B.M.'s spinal canal nor any late risk of neurological damage nor potential for entrapment. Dr. Birt commented upon the importance for R.B.M. of exercise, conditioning and stretching the musculature around his neck. He was of the opinion that R.B.M.'s neck would gradually improve over the long run and would not be causing any significant, long-term functional compromise. He felt that a final prognosis could not be offered until about one year after the date of the injury. Dr. Birt also noted that R.B.M. had sustained certain musculoligamentous injury to his cervical spine, and also felt that there might be some residual impairment in the thoracic spine although Dr. Birt did not anticipate this would be of any great degree.

[para3] Dr. Dyck, in a letter to the insurer of October 30th, 1995, describes the same injuries in slightly different language as, more simply, "collapsed vertebrae of thoracic 5, 6 and 7, as well as fractures of the ribs at C5 and C6 and fracture of the transverse process at C5 and C6".

[para4] On October 13th, 1994, R.B.M. consulted Dr. Herbert D. Rosenberg, a chiropractor at St. Pierre, Manitoba, with respect to his neck and mid-back pain. Dr. Rosenberg examined R.B.M. and arranged for X-rays of his spine to be taken, followed by spinal adjustments at a frequency averaging three times per week for close to three years, followed by continuing chiropractic care at an average frequency of twice weekly.

[para5] R.B.M. was referred by MPIC, in February of 1995, for an assessment by the Canadian Back Institute, who recommended a structured, activity-based program focusing on work-conditioning, with treatment being time limited and goal oriented, concurrent with specific education respecting his back care and some case co-ordination between R.B.M. himself, his physician and his employer. R.B.M. did, in fact, start a rehabilitation program at the Canadian Back Institute on March 2nd, but only attended for four days, after which he quit that facility because he was experiencing an increase in symptoms.

[para6] On October 5th, 1995 R.B.M. attended at Pan Am Sports Medicine Centre in Winnipeg, upon a referral by MPIC. An X-ray of his thoracic spine taken at that clinic revealed progressive healing, with "mild thoracic kyphosis" (i.e. a slightly hump-backed posture) but "no bony abnormalities". Dr. Wayne Hildhal, Medical Director of the Pan Am Sports Medicine Centre, offered the opinion that R.B.M. would benefit from a course of physiotherapy coupled with a comprehensive reconditioning program aimed at strengthening and improving his neck and back function.

[para7] R.B.M. was then referred by MPIC to Mike Manning and Associates Ltd., specialists in vocational rehabilitation services. Mr. Dan Chafe, MSW, of that organization noted that three separate parties (Dr. Hildahl, Dr. Birt and the Canadian Back Institute) had all recommended a conditioning program that had yet to be followed through, since R.B.M.'s preferred method of pain control was chiropractic treatment and rest. He recommended that R.B.M.'s medical status be reviewed by MPIC's consultants so that medical/chiropractic consultations with current practitioners might be facilitated, in the hope that this would result in an appropriate treatment plan being put into place. Dr. Gordon Dyck fully supported the foregoing concept which, however, does not seem ever to have been given effect.

[para8] Mr. Chafe then, with the approval and at the expense of MPIC, referred R.B.M. to the University of Manitoba Athletic Therapy Centre, where he was examined and assessed on January 24th, 1996. There, he was initially treated with heat pack, massage, stretching exercises for his neck and back musculature plus exercises aimed at strengthening his back extensors and abdominal muscles and, in general, increasing his range of motion. By about the end of April R.B.M. was receiving more aggressive massages, including transverse friction technique, and began stationary cycling. He also was given an exercise program booklet in which to record the number of sets of each exercise that he was working on at home. His improvement by May 1st was reported to have been slow, although he reported that he had gradually become more active and functional with less frequent and less severe episodes of pain.

[para9] In July of 1996 Dr. Dyck, following a suggestion of Mr. Chafe, referred R.B.M. back to Dr. Birt for a further consultation and for consideration of a magnetic resonance imaging of R.B.M.'s back. Due to demands upon Dr. Birt's time, R.B.M. was not able to meet with Dr. Birt until October 29th of 1996. Dr. Birt's extensive report to Mr. Chafe of October 31st, 1996 may, at the risk of oversimplification, be summarized very simply this way: R.B.M. had sustained minor compression injuries to T7 and, perhaps, T6, along with an undisplaced crack fracture of the transverse process on both the left and on the right at T5 and T6. There was no evidence of spinal instability nor any compromise to the spinal canal.

R.B.M.'s injuries had healed, as was evident from a repeat CT Scan done at the Victoria General Hospital on November 21st of 1995. He had received extensive therapy and chiropractic care but, despite any type of care, he had still not significantly improved. One would have expected him to be more comfortable and functional than he was. When examined on October 29th, 1996, there were no underlying physical abnormalities that would call for specific orthopaedic treatment or surgical invasive treatment. It was questionable whether simultaneous chiropractic care and physiotherapy would in any way benefit R.B.M. who, Dr. Birt felt, was developing chronic pain syndrome. If there were significant residual musculoligamentous pain, one would have anticipated more sensitivity to palpation and touch during examination. Also, neck rotation causing lower thoracic back discomfort, as reported by R.B.M., is not a usual or common feature. Dr. Birt felt that, unless R.B.M. could change his perception of pain and become more functional, he would not work at anything. Efforts should therefore be directed at making him more functional, whether through psychological chronic pain help or otherwise Dr. Birt was not prepared to say.

[para10] In November of 1996 R.B.M. was referred by Mr. Chafe, again with MPIC's approval, to the Rehabilitation Clinic and Research Centre ('RCRC') at the University of Manitoba Faculty of Medicine, where a return-to-work plan was developed. It was anticipated that this plan would take about twelve weeks in order to get R.B.M. back up to a forty-hour work week, assuming that all had gone reasonably well up to the eighth week. The report of Professor Heather Parrott-Howdle, of the RCRC, dated November 12th, 1996, notes that R.B.M. had had extensive strengthening and stabilization exercises at the University of Manitoba Athletic Therapy Centre, that he was very pain focused, but that the only objective findings were a mild decrease in range of motion of the neck, moderate tightness in his mid-back and neck muscles and general stiffness in his thoracic vertebrae. She added that "the minimal objective findings do not correlate with the subjective descriptions of his pain".

[para11] Following receipt of the last noted report, MPIC's adjuster wrote to R.B.M. on November 29th, 1996, to advise him that the insurer would continue to cover the cost of one chiropractic treatment per week throughout the duration of R.B.M.'s work hardening program, at which point there would be a re-evaluation.

[para12] On November 25th and 27th of 1996 R.B.M. was also seen by Dr. Ali El-Khatib, a clinical psychologist in the Department of Rehabilitation Psychology and Neuro-psychology at the Winnipeg Health Sciences Centre. These two sessions were followed by a further short term involvement of some six to eight sessions with Dr. El-Khatib, focusing on pain management techniques and alternative coping skills.

[para13] On December 5th, 1996 the RCRC at the Faculty of Medicine reported that an additional four weeks of work hardening would probably be needed in order to get R.B.M. back up to a forty-hour work week. Meanwhile, it was recommended that he not do any lifting related to his work or driving until at least the week of December 30th.

[para14] In January of 1997 R.B.M. sought an internal review of the decision, reflected in the letter of November 27th, 1996 referred to above, to reduce coverage for his chiropractic treatments. The internal review hearing was not held until May 6th, 1997 and, apparently by reason of the need to collect, analyze and refer to MPIC's own consultants the various medical, paramedical and chiropractic reports that were required, the decision of the Internal Review Officer was not made until September 29th, 1997.

[para15] Meanwhile, R.B.M.'s file had been referred to MPIC's medical service team on June 16th, 1997. On July 22nd, 1997, Dr. Neil Craton, the Medical Director of MPIC's Claims Services Department, expressed the view that R.B.M. had definitely sustained objectively documented spinal fractures as well as chest wall fractures. In Dr. Craton's opinion, the thoracic spine is the least amenable to objective documentation of clinical pathology. There is less range of motion to the thoracic spine than through the cervical or lumbar spine and assessments tend to be more subjective than in other spinal areas. Given those factors, said Dr. Craton, it seemed reasonable to think that R.B.M. might not be able to return to his pre-accident employment of long haul truck driving. He recommended that vocational efforts be made to have R.B.M. enter the work force where there was less long haul component to his driving or where he had greater control in terms of stopping and starting. Dr. Craton felt that R.B.M. might have more benefit from working in a driver education capacity, or in a non-truck-driving capacity.

[para16] R.B.M. had been receiving income replacement

indemnity, commencing effectively following the first week after his accident, as well as chiropractic care from October 13th, 1994.

[para17] On July 29th, 1997, the Occupational Rehabilitation Group of Canada provided MPIC with a brief history of R.B.M.'s employment from 1978 through 1997, together with a list of occupations for which, they felt, R.B.M. might be well suited. The Occupational Rehabilitation Group of Canada was then retained further by MPIC to proceed with a job search for R.B.M.

[para18] R.B.M.'s senior adjuster at MPIC wrote to Dr. Birt again on August 21st, 1997, seeking his advice as to whether R.B.M. had sustained any permanent impairment. Dr. Birt's response of August 25th did not indicate any compensable, permanent impairment. More specifically, he notes that "There is certainly no evidence of neurological compromise".

[para19] The Internal Review Officer of MPIC, Mr. Terry Kumka, also sought an opinion from the Corporation's chiropractic consultant, Dr. Darrell Minuk. Dr. Minuk's memorandum of September 16th, 1997 recommends a maximum of two chiropractic treatments per week for a period of four months, including some specific adjustive techniques, with a reassessment at the end of that time with a view to either reducing or extending or eliminating the chiropractic component of R.B.M.'s rehabilitation. It was upon the basis of Dr. Minuk's recommendation that Mr. Kumka, on September 29th, 1997, allowed R.B.M.'s appeal by, firstly, extending chiropractic care for R.B.M. by an additional four months at a frequency of two treatments per week and, secondly, directing that the Corporation reimburse R.B.M. for any chiropractic treatments for which he had not yet been reimbursed, also to a maximum of two per week, up the date of Mr. Kumka's decision.

[para20] Meanwhile, MPIC, through the services of Occupational Rehabilitation Group of Canada, was continuing its efforts to find alternative employment for R.B.M. and, as well, arranging for certain computer courses for R.B.M. to take at the [text deleted] at [text deleted], Manitoba, for a total of 66 hours of training at a total cost to MPIC of \$700.00. However, although R.B.M. started the computer courses, he quit after a short while, complaining of the pain that he was experiencing from sitting at the computer station.

[para21] R.B.M., who had performed volunteer work for Winnipeg Harvest from time to time before his accident, returned to that volunteer work in or about October of 1997, driving from [text deleted] to Winnipeg, working as a volunteer driver for Winnipeg Harvest and then returning to [text deleted]. R.B.M. explains his ability to do that

volunteer work but his inability to continue with his computer courses by reference to the seating in his car which, he says, was much more comfortable for his back and, therefore, could be tolerated. Added to that, he said, his work at Winnipeg Harvest allowed him to change position and the movement helped his back pain; he stiffened up if he stayed in one position too long.

[para22] MPIC authorized the purchase of a new, special chair for R.B.M. to use in connection with his computer courses and the ORGC prepared a special training schedule for him, starting with two hours per day for the first three days, then three hours, and so on, gradually increasing to six hours per day, over a period from December 3rd, 1997 to January 23rd, 1998.

[para23] On December 18th, 1997, R.B.M. filed a Notice of Appeal to this Commission against the decision of MPIC's Internal Review Officer whereby his chiropractic treatments at MPIC's expense were to have been reduced in the manner described in paragraph 19 above. R.B.M.'s Notice of Appeal alleges that chiropractic care had been the most beneficial treatment for him in reducing pain, improving function, increasing range of motion and reducing the frequency of his headaches, improving sleep patterns and improving his daily living activities. He alleges that, since the frequency of his chiropractic treatments had been reduced, his condition had been steadily worsening.

[para24] Dr. Rosenberg provided a narrative report to MPIC bearing date April 3rd, 1998. That report expresses the view that the occupational therapy for which R.B.M. had attended appeared to have done more harm than good, increasing R.B.M.'s pain and decreasing his level of function, whereas chiropractic adjustments had provided rapid pain relief with supportive care and had resulted in slow, gradual improvement. Dr. Rosenberg did not feel that R.B.M. had yet reached a plateau, and his report speaks of extensive hypomobility. Dr. Rosenberg, reiterating that R.B.M. had made slow progress under chiropractic care and that physiotherapy had not been of benefit to the patient, gave his opinion that there was ample evidence of spinal dysfunction to warrant continuing chiropractic care at a frequency of two to three times per week - occasionally even more frequently. He also felt that R.B.M. was certain to be left with a permanent impairment relative to his thoracic spine and, at the date of Dr. Rosenberg's report, was demonstrating impairment relative to a loss of cervical and lumbosacral motion in addition to impairment related to fractured vertebrae. He recommended that retraining efforts should continue and that "effective spinal care be made available on a supportive, palliative and reconstructive basis into the future".

[para25] MPIC then referred R.B.M. for an 'independent chiropractic examination' by Dr. Brian Lecker. Dr. Lecker, in the course of a very extensive report to MPIC bearing date April 28th, 1998, found no signs of any progressive lesion nor any evidence of neurological deficit. He offered the opinion, supporting that of Dr. Birt, that any fractures sustained by R.B.M. had healed by the time of Dr. Lecker's examination. He concluded that R.B.M. had developed chronic benign pain which was a separate condition unto itself and one which represented the first stage of chronic pain syndrome. Dr. Lecker described chronic benign pain as "a self-sustaining, self-reinforcing and self-generating process - not a symptom of an underlying injury but an illness unto itself". Dr. Lecker goes on to note that, in this condition, pain perception is enhanced with pain-related behavior being disproportionate to any underlying noxious stimulus, which has likely healed and no longer served as an underlying pain generator. While R.B.M.'s pain was certainly real, said Dr. Lecker, it had been unresponsive to treatment.

[para26] Dr. Lecker recommended that R.B.M. should continue with home exercises. Since R.B.M.'s care to date had not provided sufficient relief to enable him to return to the workforce, and since by that time it was three and a half years post-accident, Dr. Lecker felt that R.B.M.'s chances of returning to and maintaining his original job were almost negligible. "Any treatment at this point, which is not function-based, in my opinion, would be futile", said Dr. Lecker. "In essence, his best form of treatment would be a return to work as this in itself would be therapeutic. After being off 3.5 years, his symptoms may very well increase initially, however I would not anticipate a deterioration physically in his condition. As for further chiropractic care, a continuance of more of the same will likely not alter his residual symptom expressions".

[para27] Dr. Lecker's report concludes with the comment that he believed R.B.M. to be capable of returning to the workforce, if not as a long distance truck driver than in some capacity such as dispatcher, or working in parts and inventory. He felt, therefore, that the matter of returning R.B.M. to the workforce and or of his retraining should be pursued as soon as possible. He felt that prognosis remained guarded and, at that point, would be largely dependent upon R.B.M. himself. Dr. Lecker felt that any suggestions that continuing, supportive care might be needed should be subject to a trial period of withdrawal, to determine the necessity of such care.

[para28] In keeping with Dr. Lecker's last-noted suggestion, on June 25th of 1998 MPIC's own chiropractic consultant, Dr. Darrel Minuk, recommended a trial program of complete withdrawal by R.B.M. from chiropractic treatments for

two months, with the independent examination to take place at the conclusion of that period. R.B.M. was advised of that decision by letter of July 22nd, with a re-assessment of R.B.M. by Dr. Lecker being scheduled for September 25th, 1998.

[para29] R.B.M. was also examined and assessed, presumably upon a referral from Dr. Rosenberg, by Dr. Daniel A. Schaeffer, a chiropractor, on April 30th, 1998. Dr. Schaeffer's report to Dr. Rosenberg, which for some reason does not seem to have been rendered until July 21st, 1998, contains a diagnosis of "a traumatically induced torsional sprain/strain to the cervical spine with post-concussive injury. The headaches appear cervicogenic in origin and with continued treatment should continue to subside". Dr. Schaeffer also finds that "the lumbopelvic region was also subjected to a torsional sprain/strain, creating what appears to be a chronic instability in the left sacroiliac articulation with probable radicular changes stemming from the lumbar spine. There are attendant radicular changes into the upper extremities and apparent discal involvement in the dorsal, lumbar and cervical regions".

[para30] Dr. Schaeffer, noting that R.B.M. was receiving supportive care for control of his pain at the time of Dr. Schaeffer's examination, felt that R.B.M. would continue to be irritated by most of his aggravations for some time to come, considering the physical impact that the accident had had upon R.B.M.'s system. Dr. Schaeffer said that he expected to see strengthening of the damaged muscular tissue as time progressed, formation of scar tissue along the torn ligamentous regions and neural changes with the natural process of impingement. We must note that Dr. Schaeffer's report seems to be at odds with those of Dr. Birt and Dr. Lecker, who found no neurological deficits.

[para31] As noted above, on September 29th, 1997 MPIC's Acting Review Officer had extended the number of chiropractic adjustments for which MPIC was willing to pay, for a further period of four months at a frequency of two per week, and also authorized payment for any previous treatments that had not already been paid for, limiting those to two per week. In fact, MPIC continued to pay for chiropractic treatments for R.B.M. at a frequency of two per week until July 22nd, 1998, when R.B.M.'s Adjuster had written to tell him that, following the advice of MPIC's consultants, a trial period of two months of total withdrawal from chiropractic treatments would be instituted.

[para32] When R.B.M. attended for re-examination by Dr. Lecker on September 25th, 1998, it was apparent that the recommendation of Drs. Lecker and Minuk that chiropractic treatments be discontinued for a trial period of two months had not, in fact, been followed. R.B.M. had seen Dr.

Schaeffer, as noted above, and had also seen his new family physician, Dr. Gobeil, who had apparently advised him to "find a job that he could handle". However, R.B.M. had continued to see Dr. Rosenberg about twice a week until August, when he did discontinue chiropractic treatments for three weeks only. He then recommenced chiropractic adjustments with Dr. Rosenberg, on an average of twice a week. R.B.M. felt, by September 25th of 1998, that he had improved to a fairly substantial degree.

Dr. Lecker saw no reason to change his original diagnosis and had no further recommendations to offer. He felt that R.B.M.'s best form of rehabilitation would be a return to the workforce, possibly in a self-employed capacity and, to the extent practicable, in work similar to that to which R.B.M. had been accustomed prior to his accident. Dr. Lecker felt that R.B.M. had reached maximum therapeutic benefit in the context of chiropractic care and that ongoing care of that nature would not resolve his residual symptom expressions. Dr. Lecker, while questioning the necessity for care at a frequency of one to two times per week, felt that the necessity for supportive care had yet to be established and that this aspect of R.B.M.'s rehabilitation should be reviewed by MPIC's in-house consultant.

THE ISSUE:

[para33] The issue before us is whether MPIC is responsible for continuing chiropractic care of R.B.M. beyond July 22nd, 1998.

DISCUSSION:

[para34] The Clinical Guidelines for Chiropractic Practice in Canada, being the proceedings of a consensus conference commissioned by the Canadian Chiropractic Association and held in April of 1993 were adopted not only by the Canadian Association but, more specifically, by the Manitoba Chiropractors' Association. It must be emphasized, of course, that Guidelines are just that, and no more; their recommendations are not binding rules of conduct. On the other hand, having been prepared by a highly respected group of practitioners, those recommendations must be accorded a fair amount of weight. Dr. Rosenberg testified that he does not agree with the Clinical Guidelines - "I don't base my care on those guidelines but what I see in my patient with my own perception of his rate of improvement". The fact is, however, that R.B.M. appears to have received something well in excess of 500 chiropractic manipulations since October 13th, 1994. The evidence of Dr. Rosenberg was that his chiropractic care consisted of "specific spinal adjustments of involved aberrant spinal motor units, primarily in the thoracic spinal and cervical spine and secondarily in the sacroiliac articulations". He reports that "mobilization and adjustment of the right glenohumeral joint and associated soft tissues"

had been required to reduce pain and maintain function of the right shoulder.

[para35] Dr. Rosenberg and Dr. Schaeffer both refer to the course of treatments that R.B.M. has been receiving for some time past as 'supportive care', which is defined by the Clinical Guidelines as

necessary treatment/care for patients who have reached maximum therapeutic benefit, and for whom periodic trials of therapeutic withdrawal have led to deterioration and failure to sustain previous therapeutic gains. This form of care is initiated when the clinical problem recurs.

[para36] From that definition, it seems clear that R.B.M.'s caregivers have unanimously concluded that he had, indeed, reached maximum therapeutic benefit. The recommendations of Drs. Lecker and Minuk, advocating a complete withdrawal from chiropractic treatments for a period of two months, are in line with the foregoing definition of supportive care but, as we have noted earlier in these reasons, do not seem to have been given full effect. Until that trial has been conducted and R.B.M. properly reassessed at its conclusion, there is not in our opinion sufficient evidence to warrant the continuance of supportive care beyond the date when MPIC discontinued paying for it, namely July 22nd, 1998.

[para37] It is clear that R.B.M. presents as a complicated case, defined, by the Clinical Guidelines as

a case where the patient, because of one or more identifiable factors, exhibits regression or delayed recovery in comparison with expectations from the natural history.

[para38] However, it is clear that treatments of the frequency and over the period of time reflected in R.B.M.'s case raise a very real risk of chronicity or the development of dependency. As the Clinical Guidelines express it: "treatment/care can be more rationally based and be shown to have therapeutic need when the natural history and modifying factors from the patient's lifestyle and environment are considered".

[para39] It is our understanding that MPIC's external consultants are continuing their efforts to find suitable employment for R.B.M., commensurate with any vestigial problems from which he might still be suffering as a result of his accident. We are of the view that these efforts, if they result in his successful placement in new employment, will provide the best possible therapy, enabling R.B.M. to become less pain focused and, to put it in the vernacular, to get on

with his life. This is not to say that he may not need some continuing measure of supportive, chiropractic care, but the need for that has not yet been determined because an adequate period of total withdrawal has yet to be tried. The evidence indicates that, during the first few weeks following such total withdrawal, R.B.M. may well experience a greater degree of discomfort than he finds acceptable, but it will be necessary for him to work through that in the expectation that he may emerge from that trial period with a heightened awareness of his own abilities and a lessened consciousness of pain.

[para40] In the context of potential employment, it was never made clear to us whether R.B.M. had, in fact, completed the computer courses upon which he had embarked but which were interrupted by his apparent, physical discomfort. We do know that MPIC authorized the purchase of an more ergonomically suitable chair for R.B.M.'s use in pursuing those courses, but if he has not taken full advantage of that opportunity, the expense for which has also been approved, he should most certainly do so now.

DISPOSITION:

[para41] In sum, then, while MPIC is continuing its efforts, through its outside consultants, to complete suitable training and to find appropriate employment for R.B.M., and while MPIC is apparently continuing to pay him income replacement indemnity, we are not satisfied, upon the evidence, that continued chiropractic care past July 22nd, 1998 is a necessary factor in his rehabilitation. That, in our view, is something that can only be determined after a total withdrawal of chiropractic treatments for a period of two months, followed by a detailed and independent reassessment. If that is to take place, our recommendation would be that the further reassessment be conducted by someone other than Dr. Lecker. This comment does not imply, in any way at all, a criticism of Dr. Lecker nor a lack of faith in his judgment. Rather, we emphasize the importance to R.B.M. that any further reassessment not only be independent, but be seen by him to be independent and not 'tainted' by the previously expressed views of the assessing chiropractor.

[para42] For the foregoing reasons, we are obliged to dismiss R.B.M.'s appeal, subject to his right to reapply through his Adjuster for the resumption of chiropractic care if, following the period of withdrawal and subsequent reassessment referred to above, that resumption is perceived to be medically necessary.

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