Manitoba

Automobile Injury Compensation Appeal Commission

IN THE MATTER OF an Appeal by M.C.
AICAC File No.: AC-03-79

PANEL:	**Ms. Yvonne Tavares, Chairperson** **Ms. Barbara Miller** **Mr. Paul Johnston**
APPEARANCES:	**The Appellant, M.C., appeared on his own behalf, assisted by M.C.;** **Manitoba Public Insurance Corporation ('MPIC') was represented by Mr. Mark O'Neill.**
HEARING DATE:	**April 8, 2004**
ISSUE(S):	**Entitlement to Permanent Impairment Benefits.**
RELEVANT SECTIONS:	**Sections 127 and 129 of The Manitoba Public Insurance Corporation Act (the 'MPIC Act') and Section 2 and Schedule A of Manitoba Regulation 41/94.**

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 Appellant was involved in a motor vehicle accident on August 18, 1995. As a result of the injuries which he suffered in that accident, the Appellant sustained permanent physical impairments which, pursuant to Section 127 of the MPIC Act, entitle him to a lump sum indemnity in accordance with the Regulations to the MPIC Act. The Appellant is appealing the Internal Review decisions, dated May 15, 2003 and September 25, 2003, respectively, with regards to the permanent impairment benefits as determined by MPIC.

Section 127 of the MPIC Act provides that:

> **Lump sum indemnity for permanent impairment**
> **127** Subject to this Division and the regulations, a victim who suffers permanent physical or mental impairment because of an accident is entitled to a lump sum indemnity of not less than $500. and not more than $100,000. for the permanent impairment.

The Regulations set out the amount available for each type of permanent impairment as a percentage of the total amount available.

The Internal Review decision, dated May 15, 2003, confirmed the case manager's decision of October 18, 2002, which had determined a total permanent impairment benefit of 23%. This impairment benefit had been calculated as follows:

Permanent Impairment	**Percentage**
Partial hypothyroidism	10%
Diabetes insipidus	6%
Facial asymmetry	4%
Vertigo	2%
Alteration of cerebral tissue	2%
Total	**24%**

(*an adjustment in the total percentage pursuant to the Table of Successive Remainders, resulted in a decrease of 1% and therefore the total permanent impairment benefit was based upon 23%)*

In May 2003, an additional permanent impairment benefit of 20% was awarded to the Appellant for non-psychotic mental disorder. This amount was also adjusted in accordance with the Table of Successive Remainders, which resulted in a further adjustment to the total permanent impairment benefit to 40%.

The total of 40% when applied against the $101,400.00 maximum impairment benefit payable in

1995, resulted in a total impairment benefit in the amount of $40,560.00 paid to the Appellant. A subsequent Internal Review decision dated September 15, 2003, confirmed the case manager's decision of October 18, 2002 which denied the Appellant a permanent impairment benefit for organic brain injury.

The Appellant has appealed from both the Internal Review decisions, dated May 15, 2003 and September 25, 2003, to this Commission, with respect to his entitlement to permanent impairment benefits arising from the motor vehicle accident of August 18, 1995.

Prior to the appeal hearing of this matter, a fresh decision dated April 6, 2004 was issued by MPIC's case manager with regards to the Appellant's entitlement to permanent impairment benefits arising out of the motor vehicle accident of August 18, 1995. This decision awarded the Appellant the following permanent impairment benefits:

Permanent Impairment	**Percentage**
Partial hypopituitarism	16.875%
Organic brain syndrome	15.000%
Diabetes insipidus	5.000%
Alteration of cerebral tissue	2.000%
Total	**38.875%**

(this amount, when adjusted in accordance with the Table of Successive Remainders, resulted in an award of 36%)

The total of 36% when applied against the $101,400.00 maximum impairment benefit payable in 1995, resulted in a total impairment benefit in the amount of $36,504.00, which MPIC determined as the actual amount which should have been paid to the Appellant on account of permanent impairment benefits.

At the appeal hearing, the Appellant accepted the permanent impairment benefits for partial hypopituitarism, organic brain syndrome, diabetes insipidus, and alteration of cerebral tissue, as calculated by MPIC. However, he proceeded with his appeal with respect to his entitlement to permanent impairment benefits for the following:

1. Right elbow dysfunction and scarring;
2. Vertigo;
3. Restriction of neck range of motion;
4. Facial asymmetry; and
5. Non-psychotic mental disorder.

1. Right elbow dysfunction and scarring

In her report dated January 4, 2003, Dr. Petrilli comments that on January 29, 1996, the Appellant reported pain and restriction in his right elbow, subsequent to doing push-ups at the gym. The gym membership had been authorized for M.C. so he could continue with the strengthening exercises taught to him at Ness Chiropractic Clinic.

Dr. Fredette, in his report dated December 9, 2002, indicates the following:

> I would also like to comment on his right elbow dysfunction and subsequent scarring. Following his MVA, [M.C.] started demonstrating inability to fully straighten his elbow and occasional locking. This was not a problem pre-accident. The locking never happened pre-accident. Initial exam did show a lack of full extension by 5 to 10 degrees and similarly on full flexion. X-ray at the time revealed loose bodies, one anteriorly and one posteriorly. It is my understanding that clinically these loose bodies are unlikely a result of MVA. However they may have been dislodged requiring him to have surgery. He was assessed by Dr. Warren Froese who proceeded with the surgery and removal of the loose bodies. Since the surgery, he cannot fully straighten out his elbow and cannot carry objects heavier than 5 lbs. for long periods of time. The elbow often hurts and has a loss, I would estimate, at 5 to 10 degrees in full extension and flexion. This, on top of all his other problems, does limit him on activity for his arm. If possible, I would like this impairment reviewed as [M.C.] definitely demonstrates permanent loss of function of his elbow since the surgery.

Dr. Froese reviewed M.C. at the request of Dr. Fredette, for the difficulties with his right elbow. In his report dated July 7, 1997, Dr. Froese states that:

> . . . . [M.C.] had surgery May 30th in the form of arthroscopy on his right elbow, removing three large loose bodies. At the same time findings were of degenerative changes in the radiocapitellar joint which overall are longstanding.
>
> As mentioned to you in my previous letter of February 25th, 1997, I cannot directly establish a link between the motor vehicle accident and his elbow injury other than a historical one. Certainly the findings in his elbow would be in keeping with someone who was active using his upper extremities as a carpenter.
>
> It is certainly possible that the motor vehicle accident enhanced or aggravated pre-existing conditions which were subclinical up until the time of the accident.

In his Inter-Departmental Memorandum dated February 7, 2003, Dr. Radhakrishna, notes the following with regards to the assessment of the Appellant's right elbow dysfunction and related scarring:

> According to the medical file, [M.C.] began noting right elbow pain in December 1995. This would be approximately four months after his motor vehicle collision. He eventually was referred to Dr. Warren Froese. Dr. Froese's October 21, 1996 report indicates the presence of loose bodies in the elbow joint. Arthroscopic removal of the loose bodies was done May 30, 1997.
>
> The presence of loose bodies in a joint is felt to be most commonly the result of an osteochondritis dissecans. This condition usually results from one of two mechanisms. Either a subchondral fragment is displaced from one episode of significant blunt trauma or else repetitive more minor traumas can result in the same pathology. In this case, it should be noted that [M.C.] worked as a carpenter. This occupation requires extensive manual skills and repetitive movements. After his motor vehicle collision there was no mention in the medical documentation of pain in or around his right elbow. The symptoms of right elbow pain and loss of range only occurred a few months after the motor vehicle collision. While osteochondritis dissecans does not necessarily present immediately at the time of severe blunt trauma, it would be more probable for symptoms to arise sooner than four months after the fact. In [M.C.'s] case, it is more probable that the loose bodies in his right elbow joint resulted from years of repetitive elbow use rather than the motor vehicle collision in question. Accordingly, no permanent impairment is awarded for his right elbow loss of range and surgical scars.

Upon a review of all of the evidence with respect to the Appellant's right elbow dysfunction and subsequent scarring, the Commission finds that there is not a probable cause and effect relationship between the Appellant's right elbow problems and the motor vehicle accident of August 18, 1995. Given the mechanism of injury, the lack of blunt trauma to the Appellant's elbow and his previous occupation as a carpenter, we accept Dr. Radhakrishna's and Dr. Craton's assessment that it is more probable that the loose bodies in the Appellant's right elbow resulted from years of repetitive elbow use, rather than the motor vehicle accident in question. Additionally, even though the Appellant began reporting the symptoms as resulting from the strengthening program and the push-ups, there is a lack of objective evidence to connect the displacement of the fragments in the elbow to the exercise program undertaken by the Appellant.

As a result, we find that the Appellant is not entitled to a permanent impairment award for his right elbow dysfunction and related scarring.

2. Vertigo

Since the motor vehicle accident, the Appellant has suffered from dizzy spells. Despite consulting several specialists, including Dr. Janine Johnston, Dr. Ireland, Dr. Levin, Dr. Hobson and Dr. Bourque, the source of the Appellant's vertigo has not been identified. Dr. Janine Johnston, a neuro-opthalmologist and vestibular function expert, indicated in her report of April 28, 1998, as follows:

> Despite the facial asymmetry and [M.C.'s] subjective sensory deficits on his right hemi body, I could find no evidence of vestibulopathy at the brain stem level. I understand that investigations done by Dr. Ireland did not reveal any peripheral vestibular abnormalities. An MRI is apparently normal. Given the absence of any anatomical brain stem or cerebellar abnormality which would prevent vestibular compensation, even if he had a peripheral vestibular abnormality consequent to his MVA, one would have expected full compensation by this time. Failure of compensation may be resulting from neck injury,

> with inability to increase the gain of his cervical ocular reflex. As stated, there is no evidence for brain stem dysfunction involving the vestibular system, and ongoing symptoms of dizziness are most likely cervical in nature.

Since the Appellant's dizziness cannot be related to vestibular function, we agree with Dr. Craton's assessment that M.C. would not qualify for an impairment award for vertigo. Rather, as noted by Dr. Craton in his Inter-Departmental Memorandum dated April 5, 2004, dizziness is a common consequence of brain injury and the Appellant's dizziness is likely part and parcel of that impairment award.

3. Restriction of neck range of motion

The Appellant has reported a loss of range of motion of his neck since the motor vehicle accident. The Internal Review Officer, in her decision dated May 15, 2003, declined to award a permanent impairment benefit for loss of range of motion of the neck, citing the following reasons:

> In a CARS note dated October 28, 2002 Fern Ross discusses a conversation that he had with Dr. Stitz October 16, 2002. In that conversation Dr. Stitz advises that there is no award for the range of motion for the cervical spine because it is very difficult to get an accurate measurement of any disability. The reason for this is that there are seven segments which move in unison. If you look at a reading from the lower portion and then took a reading starting from the upper portion it would be different. Dr. Stitz reviewed Heather Howdle's report and stated that the measurements would not get an impairment award. I see no medical evidence to contradict this information and therefore I am confirming that there is no permanent impairment for the neck range of motion.

According to Dr. Craton, a permanent impairment benefit has not been awarded because no awards for neck range of motion restriction are provided for in the applicable Impairment Manual.

The fact that there are no awards for neck range of motion restriction in the applicable Schedule of Permanent Impairments is not necessarily determinative of the issue before us. Otherwise, ss. 129(2) of the MPIC Act would serve no purpose. Subsection 129(2) of the MPIC Act provides that:

> **Impairment not listed on schedule**
> **129(2)** The corporation shall determine a percentage for any permanent impairment that is not listed in the prescribed schedule, using the schedule as a guideline.

The amended Impairment Schedule, which came into force on April 15, 2000, provides the following permanent impairment benefit:

> **Division 1, Subdivision 3, 1. Cervical Spine**
> (d) impaired active range of motion of the atlanto-axial joint (C1 and C2), following a fracture or ligamentous injury, as documented by evidence of range of motion restriction in rotation (inclinometer method) 2.5%

Contrary to the reasoning provided by the Internal Review Officer in her decision, the award provided for in the amended Impairment Schedule for impaired cervical range of motion specifically contemplates measurement of the restriction in rotation by the use of an inclinometer. Clearly, the difficulty of obtaining an accurate measurement of a disability cannot be a reason for its non-existence.

Certainly, if the Commission were satisfied as to the permanency of the restriction in the Appellant's neck range of motion, it could invoke ss. 129(2) of the MPIC Act and determine an appropriate percentage for the permanent impairment. However, the permanency of the Appellant's restricted range of motion and its underlying cause, pose a difficulty in assessing whether a permanent impairment benefit is applicable in this case.

In his report dated August 25, 1997, respecting his initial assessment of the Appellant, Dr. Arneja noted that the Appellant's cervical spine range of motion was full, but associated with posterior neck muscle tightness and discomfort. In his report dated December 4, 1997, Dr. Arneja noted the following:

- At his initial treatment visit, on October 1, 1997, the Appellant's cervical spine range of motion was grossly restricted in all directions and all neck movements were painful.
- On October 20, 1997, the Appellant reported increased range of motion of his neck in all directions along with decreased pain in the posterior neck and in the left upper trapezius.
- On October 24, 1997, the Appellant's range of motion of the cervical spine was full in flexion, extension and rotation, right and left.
- On November 10, 1997, the Appellant's cervical spine range of motion was full in flexion, extension, rotation right and left, as well as lateral bending to the right. However, lateral bend to the left had a slight restriction.
- On November 17, 1997, the Appellant had full active range of motion of the cervical spine. This was a dramatic improvement compared to the grossly restricted and painful range of motion of his cervical spine when Dr. Arneja first examined him on June 27, 1997.
- On November 24, 1997, the Appellant had restoration of normal range of motion of the cervical spine with elimination of most of the neck, upper trapezius and shoulder pain, except for the right upper trapezius (not acute).

In a report dated May 1, 2002, from Heather Howdle, physiotherapist, the Appellant's neck range of motion was assessed and limitations in flexion and rotation were noted. In a report dated January 4, 2003, Dr. Petrilli, the Appellant's chiropractor noted that M.C.'s neck range of motion remained limited and painful. Flexion, extension and rotation were significantly reduced at that time.

Based upon the above-noted variations in the Appellant's cervical range of motion, we find that the Appellant's restricted neck range of motion is not permanent. It appears to improve and

worsen. Most significantly, when the Appellant was undergoing treatments with Dr. Arneja, his cervical range of motion was restored. This leads us to the conclusion that there are treatment options available for the Appellant to address the restriction in his cervical range of motion and that his restricted neck range of motion is not a permanent sequela of the motor vehicle accident. Therefore, we find that there is no permanent impairment benefit applicable for the restriction in neck range of motion.

4. Facial asymmetry

In the latest decision, MPIC has determined that since the source of the Appellant's facial asymmetry is unknown, there can be no impairment award at this time.

The existence of a facial asymmetry for this Appellant is not disputed. Several of the Appellant's physicians have commented on the facial asymmetry. Dr. Hobson in his report dated March 8, 1996 noted that:

> **NEUROLOGIC EXAM:** Examination of his cranial nerves reveals a reduced right ocular aperture and right pupil that is just slightly smaller than the left. He has a crooked face and it is very difficult to know, even talking to him and his wife, whether this is new or old but, one might think it may be new because of the comments about his "nose looking crooked". The mouth angles downward from right to left and the nasolabial fold on the left is definitely not as pronounced as the right. The left face also moves less quickly than the right, although total power seems to be preserved. The fundoscopic exam is normal, although there are a few beats of nystagmus evident when one is looking in his eyes. Gazes are full without double vision. Visual fields are full. Hearing is normal. The tongue and palate are midline and move well. There is no significant weakness of the sternocleidomastoid or trapezius muscles.

Dr. Bourque, in his report dated January 8, 2001, commented that:

> On physical exam, he seemed in no acute distress. I heard no cranial or carotid bruits. His fundi were unremarkable and her (sic) visual fields full to confrontation. The ocular movements were normal, he has some flattening of his left nasolabial fold and diminished sensation over the left side of the face including diminished corneal sensation. Examination of his limbs showed normal power, tone, coordination, reflexes. His toes

> were downgoing to plantar stimulation. The sensory exam revealed a deficit over the right side of his body for temperature and pinprick. Vibration sense was also diminished on the right vs. the left. His position sense seemed normal. His cardiovascular exam was unremarkable.

Dr. Fredette, in his report dated May 5, 2002, indicated that:

> On neurological review, [M.C.] has chronic numbness to the left side of his face with also drooping to his mouth. There is numbness to the right side of his body. He also gets the sensation of not getting goosebumps on the right side of his body.
>
> On neurological exam, he has a diminished sensation on the left side of his face including a decreased corneal sensation in the left eye. He has deficits on the right side of his body from the neck down for temperature, pin prick and vibration, however his position sense appears to be normal.

At the hearing of this appeal, both the Appellant and his wife testified that the drooping on the left side of the Appellant's face has occurred since the motor vehicle accident.

Upon a review of all of the evidence on the file, the Commission finds that, on the balance of probabilities, the Appellant's facial asymmetry is related to the motor vehicle accident. Dr. Craton was hesitant to ascribe an impairment benefit for M.C.'s facial asymmetry based upon a seventh cranial nerve abnormality. However, on neurological examination, Dr. Bourque reported findings of "*diminished sensation over the left side of the face including diminished corneal sensation*". These findings were endorsed by Dr. Fredette. Additionally, the preponderance of medical information indicates that M.C. did sustain a brain injury. The location of the brain injury was best described as the brainstem region, close to the originating fibers of the seventh nerve, with interference of the spinothalmic tract. The Commission also accepts the evidence of M.C. and M.C. that the facial asymmetry occurred after the motor vehicle accident. As a result, the Commission finds, on the balance of probabilities, that the Appellant's facial asymmetry is related to the motor vehicle accident and was most probably related to the deep brain injury suffered by the Appellant in the motor vehicle accident.

Accordingly, the Commission finds that the Appellant is entitled to a permanent impairment benefit of 4% in accordance with Part 2, Division 2, Table 15 for his facial asymmetry. The Appellant shall be entitled to interest on this sum from the date of the motor vehicle accident, to the date of payment.

5. Non-psychotic mental disorder

In his report dated August 23, 2001, Dr. Stambrook, clinical psychologist and neuropsychologist, commented as follows with regards to the Appellant's pain and illness behaviour and his entitlement to a permanent impairment benefit for same:

> Based on what I have reviewed, he has the following as now robust and most likely enduring deficits given the fact that his injury occurred in 1995:
>
> 1. Mild-moderate cognitive deficits.
>
> 2. Somatic focus and significant lifestyle alterations.
>
> It is very difficult to pull these apart given the confluence of factors here, but this man is functionally disabled from the information I have. His lifestyle is permeated by his pain experience, with his everyday activity absolutely determined by the nature of his headaches and by his vertigo. This is a major influence here, as are the issues with his sleep disturbance.
>
> However, the fact that he made gains on this assessment does indicate that he had reasonable effort. The fact that his performance, in almost all respects, is absolutely identical over the course of time, albeit for slight variations, gives increased confidence with this.
>
> Based on this, given that the current request is for evaluation regarding the Permanent Partial Impairment award, he does have abnormalities in some areas of higher order problem solving, some robust difficulty in his topographical localization memory, robust difficulty in his discrimination of rhythmic patterns, robust weaknesses in his information processing speed and, in his attention and concentration. He has weaknesses as well in many areas of his memory. Obviously pain, the use of narcotic analgesia, and sleep disturbance plays some role, but these results have been relatively robust over the course of time.
>
> The rating I would given would be as follows:

. . . . .

2. This man does not have a Personality Disorder nor a psychosis, but does have, in my opinion, a Non-Psychotic Mental Disorder that plays a role here, in regards to the somatization and what I see as the Pain Disorder with Physical and Psychological Perpetuating Factors. It is very difficult to clearly evaluate this as I believe this man minimizes. My rating here is in the Category 10 range. He requires constant (daily) use of therapeutic measures, and there has been a change in his everyday activities leading to marked reduction in his social and personal achievement. He continues to require symptomatic treatment and interruption of regular activities, including the side-effects of medications. I rate this in the 50% range.

In his Inter-Departmental Memorandum dated February 18, 2002, Dr. Craton indicates as follows with respect to the Appellant's entitlement to a permanent impairment benefit for non-psychotic mental disorder:

> With relationship to the issue of the Non-Psychotic Mental Disorder, I would offer the following:
>
> - To be considered a Pain Disorder, an individual must meet the following diagnostic criteria.
>
>   a) There must be pain in one or more anatomical sites that is the predominant focus of the clinical presentation and has sufficient severity to warrant the clinical attention.
>
>   [M.C.] appears to satisfy this criterion.
>
>   b) The pain must cause clinically significant distress or impairment in social, occupational or other important areas of functioning.
>
>   [M.C.] appears to meet this criterion.
>
>   c) Psychological factors must be judged to have an important role in the onset, severity, exacerbation or maintenance of the patient's pain.
>
>   [M.C.] clearly does not meet this criterion.
>
>   d) The symptom or deficit must not be intentionally produced or feigned as in factitious disorder or malingering.
>
>   There is some concern whether [M.C.] meets this criterion based on Dr.

Stambrook's correspondence.

e) The pain must not be better accounted for by mood, anxiety or psychotic disorder.

[M.C.] does meet this criterion.

Therefore, in my opinion, [M.C.] does not meet the criteria for a diagnosis of Pain Disorder. The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition – Text Revision states that a Pain Disorder must not merely be associated with a general medical condition. A Pain Disorder associated with a general medical condition is not considered to be a mental disorder. Therefore, it would not qualify for an award under the Mental Function System in the Impairment Manual. This award allows psychological factors to be present, but they are not judged to have a major role in the onset, severity, exacerbation or maintenance of the pain.

Even in the event that [M.C.] was to satisfy the diagnostic criteria for a Pain Disorder associated with psychological factors, it would be my opinion that he does not fall under the category outlined by Dr. Stambrook. Dr. Stambrook has stated the patient must have constant recourse to therapeutic measures to deal with his Pain Disorder. It is evident from review of [M.C.'s] file that he has not had constant recourse to psychological therapies, and indeed has had very little psychological treatment in his overall clinical situation. Almost all of [M.C.'s] treatment has focused on his general medical condition.

Dr. Stambrook provided a further report dated January 9, 2003 commenting on M.C.'s permanent impairment ratings and upon Dr. Craton's analysis. In this report, Dr. Stambrook indicates that:

<u>On the issue of non-psychotic mental disorder:</u>

Here, as I have assessed over the course of time, beginning with the initial assessment reflected in the March 22nd, 1999 report, [M.C.] has produced psychological findings that documented a somatoform profile. I have indicated that I felt that this was a key factor in his presentation, with pain behavior, disability behavior and problems managing his pain.

I had outlined that he had developed a pain and illness syndrome that were superimposed upon the other issues that he had. This has been the case over the assessments I have conducted, where, on each of the assessments, he has produced a somatic profile. I felt that this was a major influence in his every day life, with his lifestyle permeated by his pain experience and undermined by his headaches and vertigo. He had developed over time increased disability with this, and I have noted that his functioning has decreased from early post-accident, in terms of his status on the assessments by his chiropractor, physician, Dr. Barron and the Occupational Rehabilitation Group.

In contrast to the Manitoba Public Insurance opinion on this, reflected by the Medical Director, Dr. Craton, February 18th, 2002, there is clear evidence of psychogenic involvement, in my opinion, given the fact that this man's recovery has fallen completely off the recovery curve in multiple areas, given the previous diagnosis of musculoskeletal and ligamentus injuries. His recovery has been grossly atypical.

. . . . .

The Manitoba Public Insurance opinion is that this man has a Pain Disorder, however it is seen to be consistent with a General Medical Condition. Here, this is the crux of the matter. There has been no consensus diagnosis of any general medical condition. In my opinion this is due to the fact that this man has somatic focus, has been overtaken by his symptoms, and has developed the unhealthy complex of behavioural, expectation-based and attitudinal issues.

These were clearly apparent very early on, as he was uniformly focused on medical causation. Despite being in a multi-disciplinary pain program and offered counselling, he did not take to this and has been fairly pain focused all the way through this situation.

. . . . .

My feeling here is that [M.C.'s] personality style and somatic focus has been part of the issue. This may be related as well to the underlying deep injury he had to his brain, the diffuse axonal injury, where he has not easily made gains with this and has been limited by his pain.

This is pervasive throughout the Occupational Rehabilitation Group's assessment, and I would direct attention to the physiotherapy assessment, the appendix there, where there are multiple comments that he was limited by pain in his movements, hence playing an obvious role in his functioning. The fact that [M.C.] did not involve himself in the pain management to any great extent I believe is reflective of his psychological dynamics. The fact that the specialists who he saw did not identify psychological issues is due to the fact that [M.C.] did not present them, as he is presenting his state as he knows it, and there is a lack of insight into the psychological dynamics. This again is part of the dynamic associated with the development of a Pain Disorder with Psychological and General Medical Factors.

The Manitoba Public Insurance review does not believe that psychological factors have an important role in the onset, severity, exacerbation and maintenance of the patient's pain. I however do not agree with this. This man was involved in a high velocity accident. His family had injuries and there was worry regarding his family. There was a fatality involved in this accident and [M.C.] had unpleasant symptomatology he was uncomfortable with. This has now led to multiple years of change in functioning, from the information I have, uncontested at this point by other information. He has had a change in family functioning, financial status, occupational role and role within his family.

This has been documented by [M.C.'s] own statement, undated but contained in the Manitoba Public Insurance information. He has had the sense that his life has been

“shattered” and that his financial stability has been “stolen from him”. Hence, the accident has become a watershed event, and there are multiple changes in his functioning.

. . . . .

I do believe that psychological factors play an important role in maintenance here and have indicated this previously on multiple occasions. Unless there is going to be evidence of motivational distortion and misrepresentation of functioning, [M.C.] has had lifestyle change and pain focus, where he has pain in one or more anatomical sites, sufficient severity to warrant clinical attention, and psychological factors have important role in the onset, severity, exacerbation and maintenance of his pain. I believe he clearly meets this criteria as there has been no underlying pathophysiological entity otherwise to explain the level of functional problems he has.

I have been unable to dismiss his symptoms as due to malingering, although I have raised the issue of voluntary exacerbation on my own testing. However, unless there is more specific information and additional information, which is not apparent in the Manitoba Public Insurance documentation, I cannot entertain this at this point.

The other issue raised by Manitoba Public Insurance is that the patient must have, in the Manitoba Public Insurance rating, “constant recourse to therapeutic measures to deal with his Pain Disorder”. The Manitoba Public Insurance review focuses on “constant recourse to psychological therapies”. I do note from the actual statement on Subdivision 3 of Non-Psychotic Mental Disorders, there is <u>no</u> statement here that he has to have constant recourse to <u>psychological or psychiatric treatment modalities</u>. I have indicated in my report from August of 2001 that [M.C.] does have constant (daily) recourse to therapeutic measures, his narcotic analgesia, and there is a change in every day duties leading to a marked reduction in his social and personal achievement. This includes the side-effects of medication. This is outlined in his personal statement and has been outlined to me as well. I have no other information on this at this point.

Keep in mind that my own assessment is based on this man’s office visits, the neuropsychological review where he presented in a very pained manner, and the variability in his own mental status that he has presented to me and I believe others. He has had intensive assessment previously with Dr. Baron, Dr. Petrilli and his own family physician. He has gone through an intense at the Occupational Rehabilitation Group, albeit six to seven years previously. Nowhere have there been statements made regarding motivational impairments or ingenuineness of his symptoms.

My sense is that the perpetuation of his symptoms have to do with the combination of his general medical condition and his psychological state, hence the ratings I have made, with this in the context of the underlying musculoskeletal injuries he has had, and the diffuse axonal injury, given findings that are obviously not under voluntary control, those related to the metabolic findings and hemifacial weakness. He has received a rating for this and has obviously been seen to have legitimacy, and has received a rating for the metabolic defect which obviously has legitimacy.

In an Inter-Departmental Memorandum dated January 28, 2003, from Dr. Radhakrishna and Dr. Craton, an assessment was made that M.C. qualified for an impairment benefit of 20% based on a Category 11 Impairment in the Manitoba Public Insurance Schedule of Permanent Impairments.

In an Inter-Departmental Memorandum dated March 5, 2003, Dr. Craton reinforced his opinion that the Appellant was entitled to a permanent impairment award for non-psychotic mental disorder, where he indicated that:

> As such, it is inappropriate to rate [M.C.] for his impairment at this time as it may not be permanent, stable and at maximum medical improvement. Therefore, I would suggest waiting six months to see if there is any change in [M.C.'s] condition above and beyond that described by Category 11 in the Impairment Manual as referred to in the January 8, 2003 correspondence.
>
> It is my opinion, that on the balance of probability, it is unlikely that [M.C.'s] condition will improve beyond that described in Category 11. Therefore, it would be reasonable to forward him the impairment award for Category 11, and reassess his file in approximately six months to see if he is having constant recourse to therapeutic measures and continues to have a marked reduction in personal and social achievement. It would be these two variables, which may change, and increase the patient's permanent impairment award.

Subsequently however, Dr. Craton reassessed the Appellant's situation and determined that the Appellant was not entitled to an award for non-psychotic mental disorder. Specifically, in his report of April 5, 2004, Dr. Craton states that:

> The notion of the award for a pain disorder has emanated from the patient's psychologist, Dr. Stambrook. Dr. Stambrook has spoken at length regarding the patient's permanent impairment award and I would refer the reader to the January 9, 2003 correspondence which is in Tab 18. In the first six pages of that correspondence, Dr. Stambrook establishes that the patient, although highly atypical, has sustained a brain injury. This would obviously represent a traumatic brain injury. On page 7 of his report, Dr. Stambrook describes what he considers the "*crux of the matter*" in relationship to the patient's award for pain disorder. He states that it has been Manitoba Public Insurance's opinion that [M.C.] has a pain disorder secondary to a general medical condition.
>
> Dr. Stambrook is accurate in that reflection, as per my previous memorandum I have

referred to. For the benefit of the reader, The Diagnostic and Statistical Manual of Mental Disorders 4th Edition text revisions commonly referred to as DSM-IV-TR, describes the idea of a pain disorder on page 503. The criteria for the pain disorder have been reviewed previously. A pain disorder is considered a mental disorder if it is associated with psychological factors, or psychological factors and a general medical condition. Obviously, [M.C.] has a medical condition which has emanated from his motor vehicle collision. The option is whether the patient also has psychological factors as well as the medical condition being judged to have an important role in the onset, severity, exacerbation or maintenance of the patient's pain. Clearly, the onset, severity, exacerbation and maintenance of [M.C.'s] pain needs to be critically evaluated.

The idea of a pain disorder associated with a general medical condition speaks to a general medical condition having a major role in the onset, severity, exacerbation, or maintenance of the patient's pain. If psychological factors are present, they are not judged to have a major role in the onset, severity, exacerbation, or maintenance of the patient's pain.

In my view, Dr. Stambrook's position on this matter is irreconcilable. Dr. Stambrook states that there has been no consensus diagnosis of any general medical condition. He states this in paragraph three of his January 7, 2003 report on page 7. This seems untenable given the previous six pages of that report have outlined that the patient had a "*deep brain injury*". Dr. Hobson describes brainstem injury, and Dr. Bourque describes injury to the patient's spinothalamic tract.

. . . . .

Further discussion of the issue of the pain disorder is required. The fourth criterion for the diagnosis of pain disorder, is that the patient's symptom deficit is not intentionally produced or feigned as in factitious disorder and malingering. In several of Dr. Stambrook's reports, there is evidence that the patient lacks complete veracity in his response to questions. Page 16 of Dr. Stambrook's August 23, 2001 report outlines a test of memory malingering. The patient's performance is described as substantively below expectation. The patient's performance was substantively lower than the expectation even for individuals who had very severe cognitive deficits. Dr. Stambrook stated that there was a clear possibility that this man was not putting forth his best effort on the test.

[M.C.'s] psychologic symptoms also do not sound as if they are permanent at this point and enduring. The patient seems to be described as having quite a variable psychological consequence of his pain disorder which is related to his brain injury, in my opinion. The patient is described as doing some socializing, bow hunting, and then deer hunting with a rifle. He plays hockey, and indeed was injured playing hockey with friends in his back yard. His handwritten notation of his activities of daily living indicate that he is able to perform household chores for extended periods of time, despite his pain experience. Therefore, notwithstanding the difficulty with the idea of whether this patient's pain disorder is related to a general medical condition with or without psychological factors, the award of 50% does not seem appropriate for this patient as outlined by Dr. Stambrook. I don't believe that Dr. Stambrook has adequately refuted, based on his own evidence, that the patient has evidence that he is malingering, which is a key diagnostic criteria for pain disorder. Furthermore, ongoing treatments are planned in [M.C.'s] case,

> and one cannot consider him to be at maximum medical improvement in any event in relationship to his pain treatment. This would prohibit the award of a permanent impairment for pain disorder at that time, if one was convinced that his pain disorder was not simply secondary to a general medical condition as I assert.
>
> To summarize this issue, I do not believe a permanent impairment award is appropriate for [M.C.] for his pain disorder. It is associated with a general medical condition, if one believes it exists. It is not at maximum medical improvement if one believes it exists. It has not been diagnosed in a recent psychiatric setting. Dr. Stambrook has not proven the patient is not malingering after raising this issue in his reports. If self-report is not without question, pain complaints must be carefully evaluated in relationship to impairment.

Upon a review of all of the evidence made available to it, both oral and documentary, the Commission finds that the Appellant is entitled to a 50% permanent impairment benefit for non-psychotic mental disorder based upon Category 10 of Subdivision 3, Division 9 of Part 1 of the Schedule of Permanent Impairments.

The Commission accepts Dr. Stambrook's opinion with respect to the Appellant's psychological profile. We find that Dr. Stambrook, having assessed the Appellant on several occasions and more recently having treated and followed the Appellant in his private practice, is in the best position to comment on the Appellant's psychological state. We accept Dr. Stambrook's opinion that psychological factors have an important role in the onset, severity, exacerbation and maintenance of [M.C.'s] pain disorder.

We find that the Appellant's general medical condition (i.e. the brain injury) is not the sole factor which accounts for his pain and illness behaviour, but rather the Appellant does have a psychological condition which manifests in pain. Dr. Stambrook's opinion was that although M.C. did sustain a significant brain injury, the brain injury itself was not so severe as to account for the Appellant's poor outcome since the motor vehicle accident. In his testimony before the

Commission, Dr Stambrook advised that - *the Appellant's brain was scrambled – shaken up enough to disrupt his functioning, but not so sufficient as to appear on an MRI*. Dr. Craton made a similar observation in determining whether the Appellant was entitled to a permanent impairment award for organic brain injury. In his report of April 5, 2004, Dr. Craton noted that, "*There is no significant alteration of cerebral tissue, as the MRI, even with secondary scrutiny, appears to be normal*".

Dr. Stambrook, based upon his assessments of the Appellant, determined that psychological factors account for the Appellant's markedly altered functional status since the motor vehicle accident. According to Dr. Stambrook, the psychological factors play an important role in M.C.'s lifestyle changes and pain focus and the maintenance of M.C.'s pain disorder. This has resulted in the Appellant's inability to work, his functional changes, his reduced responsibilities, his disrupted relations with family and friends, his demoralization, and significant stress and anxiety. Accordingly, Dr. Stambrook maintains that there is a lot more going on with this Appellant than tissue damage leading to his disability. He was also of the opinion that although M.C.'s symptoms might fluctuate somewhat, it was unlikely that there would be a resolution to his disorder after nine years. Dr. Stambrook also insisted that overall, taken over the entire course of his assessments of the Appellant and throughout their treatment sessions, the Appellant showed no evidence of malingering.

In these circumstances, we find that the comments and observations made by Dr. Stambrook, a clinical psychologist and neuropsychologist, who had the benefit of personally observing the Appellant and treating him throughout the relevant time, must be preferred to those of Dr. Craton, who did not have the opportunity to personally assess the Appellant. As a result, we find that the Appellant is entitled to a 50% permanent impairment benefit for non-psychotic mental

disorder. Our review of the categories contained within Subdivision 3 – Non-Psychotic Mental Disorder of the Schedule of Permanent Impairments and the voluminous evidence which we have received in respect of this matter, convinces us that Category 10 is the appropriate classification for this Appellant's impairment, and that 50% is an appropriate impairment rating.

This permanent impairment benefit for non-psychotic mental disorder together with the impairment benefit for partial hypopituitarism and organic brain syndrome shall be adjusted in accordance with Section 5 of Manitoba Regulation 41/94, taking into the account the Table of Successive Remainders. The Appellant, shall also be entitled to interest on the sum awarded by virtue of this decision, from the date of the motor vehicle accident, to the date of payment.

Dated at Winnipeg this 13th day of August, 2004.

YVONNE TAVARES

BARBARA MILLER

PAUL JOHNSTON