Automobile Injury Compensation Appeal Commission

IN THE MATTER OF an appeal by [the Appellant]
AICAC File No.: AC-98-26

PANEL:	**Mr. J. F. Reeh Taylor, Q.C., Chairman** **Mrs. Lila Goodspeed** **Mr. F. Les Cox**
APPEARANCES:	**Manitoba Public Insurance Corporation ('MPIC') represented by Mr. Tom Strutt;** **the Appellant, [text deleted], represented by [Appellant's representatives]**
HEARING DATE:	**November 2nd, December 8th, 9th and 10th, 1998 and January 12th, 1999**
ISSUE(S):	**1. Whether Appellant entitled to resumption of income replacement indemnity and, if so, from what date;** **2. Whether Appellant entitled to further rehabilitation expenses, including physiotherapy and chiropractic treatments.**
RELEVANT SECTIONS:	**Sections 89(1), 90, 91(3), 92, 107, 110, 131, 136(1) and 138 of the MPIC Act and Section 5 of Manitoba Regulation No. 40/94.**

AICAC NOTE: THIS DECISION HAS BEEN EDITED TO PROTECT THE APPELLANT'S PRIVACY AND TO KEEP PERSONAL INFORMATION CONFIDENTIAL. REFERENCES TO THE APPELLANT'S PERSONAL HEALTH INFORMATION AND OTHER PERSONAL IDENTIFYING INFORMATION HAVE BEEN REMOVED.

REASONS FOR DECISION

1ST MVA

The Appellant, [text deleted] was involved in two motor vehicle accidents. The first occurred on February 12th, 1995 when another vehicle, emerging from a back lane, struck [the Appellant's] car on the driver's side. [The Appellant] testified that, at the time of the collision, she was

shifting gears with her right arm. She was seen on February 17th by [Appellant's doctor #1], who diagnosed cervical and thoracic sprain and prescribed physiotherapy at a frequency of three times per week for twelve weeks. At the time, the Appellant was [text deleted] year-old university student, enrolled in her fourth year of an [text deleted]. [Appellant's doctor #1] gave her opinion that, while the Appellant was capable of returning to her full-time studies at the university, she should avoid lifting, reaching and bending, and should try to avoid prolonged sitting or standing.

By mid-March of 1995 her next medical advisor, [text deleted], reported that the Appellant's neck and shoulder problems were clearing but she was having persistent difficulty with pain and disability at her right elbow and wrist, particularly with writing. It should be noted that [the Appellant] is described as left-hand-dominant. On April 4th, 1995, [Appellant's doctor #2] reported that the Appellant's right shoulder and scapular symptoms were resolving but that she still had considerable discomfort with her right wrist and forearm. She was wearing a velcro forearm support and he had prescribed Naprosyn.

Into May of 1995, the Appellant continued to have multiple complaints respecting her right arm - diffuse pain coming from her shoulder and into her elbow and hand, three distinct and separate forms of parasthesia, and myofascial syndrome relating to her neck and shoulder. [Appellant's doctor #3], a colleague of [Appellant's doctor #2], found X-rays of the Appellant's neck and shoulder to be unremarkable but decided to pursue nerve conduction studies of the right arm. Meanwhile, the physiotherapy [the Appellant] had been receiving at [text deleted] Physiotherapy Clinic was continued until the end of May, when it was terminated since she appeared to have reached a plateau.

On July 20th, 1995 the Appellant attended upon [text deleted], chiropractor, who arrived at much the same diagnosis as had the Appellant's medical advisors; he prescribed manipulation to mobilize her right shoulder, together with manipulation of the fourth thoracic segment and electrical percussive massage, all at a frequency of twice per week for six to eight weeks, to be followed by a reassessment.

On September 5th, 1995 [Appellant's doctor #3] reports that, despite being supervised by [Appellant's doctor #4] and by her chiropractor at the [text deleted], with physiotherapy three times weekly having been resumed, the Appellant was making little progress and would be referred to [Appellant's doctor #5] at the [hospital] for evaluation. [Appellant's doctor #3] recommended avoidance by [the Appellant] of the use of her neck and right arm.

In October of 1995 MPIC retained the services of [vocational rehab consulting company] to coordinate [the Appellant's] rehabilitation program, with the goal of returning her to pre-accident daily activities of living.

From the initial report prepared by [vocational rehab consulting company], it appears that the nerve conduction tests carried out in June of 1995 produced normal results, although the Appellant advised [text deleted], [vocational rehab consulting company's] consultant, that she was "experiencing pinched nerves and a rotator cuff injury". She had been attending [Appellant's doctor #4] for the past two to three months and reported an improvement from 20 to 50% in the strength of her right arm. She had recently changed chiropractors and was now attending [Appellant's chiropractor #2] three times weekly. She was scheduled to see [Appellant's doctor #5] on November 6th and was also seeing [text deleted], psychologist, to assist in dealing with her chronic pain.

At that juncture (October 24th, 1995) [the Appellant] was complaining of pain in her neck, shooting into the right side of her skull from the back of her head, a "constant, solid" pain in her right shoulder with occasional numbness and decreased strength in that area, constant headaches which developed into migraines about four times per week, with continuous pain and numbness in her right arm and hand.

The first report from [Appellant's doctor #5], arising from his assessment of [the Appellant] on October 30th, 1995 notes certain deficits, specifically:

> The range of motion of the right shoulder is markedly limited actively with marked difficulty in raising the hand over the head, reaching behind the back and reaching behind the head. However, in the supine position and with distraction, the glenohumeral joint can be brought into full external rotation at approximately 110 degrees and internal rotation at approximately 70 degrees. Both shoulders showed a lot of joint play in the anterior/posterior plane consistent with ligamentous laxity.
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> The soft tissue examination reveals marked tenderness to pinch roll over the infraspinatous and supraspinatous fossae on the right. These findings are absent on the left. There is no increase in tone in the muscles above the neck and shoulder girdle including the trapezius, infraspinatous, supraspinatous, lavator scapula, sternomastoid or scalene muscles.
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> The neurological exam revealed Grade I biceps and brachioradialis reflexes bilaterally with Grade II triceps reflexes. Manual muscle testing showed breakaway weakness in all muscles tested in the right upper limb graded at approximately Grade IV. The left upper limb is unremarkable. Sensory exam is normal.
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> The segmental examination of the neck reveals tenderness throughout the articular pillars to the right of the midline from C2-3 to C6-7. There is no tenderness to the left of the midline.

[Appellant's doctor #5] went on to note that [the Appellant's] presentation had many non-organic features to it. Her description of her symptoms was very generalized and widespread, including the entire head, entire right upper limb and entire trunk posteriorly. Her physical findings displayed signs of abnormal illness behaviour and she was, as he put it

"uncharacteristically pleasant and unconcerned about what would otherwise appear to be a significant deficit". [Appellant's doctor #5] found no evidence of any neurologic deficit that could explain the degree of weakness displayed by [the Appellant]. Although she expressed concern over a "pinched nerve" of the neck or shoulder girdle, he could find no evidence of any radiculopathy nor thoracic outlet syndrome. There were no objective findings in his examination that could explain the significant amount of impairment displayed by [the Appellant]. [Appellant's doctor #5] felt that she had become dependent on passive therapies directed toward pain relief. He could find no organic lesion that could explain her symptoms and he therefore encouraged her to get involved with an isotonic exercise program to improve her conditioning. He recommended that her abnormal illness behaviour should be explored by a pain psychologist. (As noted above, she had already commenced seeing [Appellant's psychologist]. [Appellant's psychologist's] qualifications and reputation are beyond reproach, although it was never made clear to us whether she has particular expertise in the area of pain management.)

A home assessment completed by [vocational rehab consulting company] on November 14th produced recommendations for the purchase of some eight items of assistive equipment to improve her functional independence in the home environment; they were purchased for her at MPIC's expense.

On November 27th, 1995, [the Appellant] was still reporting soreness and shooting pain around her left shoulder, numerous migraine headaches every week (relieved with chiropractic treatments), a 65% improvement as the result of her hand therapy, chiropractic treatment two to three times per week giving temporary pain relief and, more recently, difficulties with her hips which, she reported, "go out" about four times a week with accompanying weakness and pain with any increased activity. She was continuing to see [Appellant's psychologist] once a week.

On December 1st, 1995, in a discussion between [vocational rehab consulting company] and [Appellant's doctor #3], there was agreement that the results of almost all of the nerve conduction studies, X-rays, connective tissue disease studies and other tests to which [the Appellant] had been subjected were normal, that the Appellant did present some myofascial pain symptoms, that her subjective complaints of pain did not match the objective results of any medical examinations and that the primary foundation of her complaints appeared to be psychological in nature. [Vocational rehab consulting company], with [Appellant's doctor #3's] approval, decided to refer [the Appellant] to [Appellant's pain management specialist] at the [text deleted], for acupuncture, and also to refer her for a functional capacity evaluation at the appropriate time.

A note on the Appellant's file, dated December 22nd, 1995, seems to indicate that she was now attending her chiropractor at a frequency of up to five times per week.

On December 21st, 1995 the Appellant attended upon [Appellant's doctor #3] for the removal of a cyst from her right wrist; thereafter, she wore a wrist splint continuously and was, indeed, still wearing such a splint at the hearing of her appeal in December of 1998. She testified that this was in order "prevent the reappearance of wrist cysts on the ganglia on top of her right wrist". She had also reported, on December 19th, 1995, that she was experiencing strong emotional fluctuations and "fits", involving outbursts of rage.

[Appellant's pain management specialist's] first report bears date January 22nd, 1996. It reflects depression, myofascial pain in the scalenes, pectoralis minor and shoulder girdle with secondary myofascial involvement of the finger and hand extensors. [Appellant's pain management

specialist] could find no evidence of neurological lesion. He also makes reference to "some chronic pain behaviours". He proposed some ten acupuncture treatments, with the opinion that some passive treatment had become necessary in order to deal with the myofascial component of her pain. He also felt it necessary that [the Appellant's] therapists "back off slightly" from vigorous exercises in her physiotherapy, until her pain was more under control. He added that a psychiatric assessment might also be useful in the future.

A few days later, in conversation with [vocational rehab consulting company], [the Appellant] said that she had applied for admission to a two-year [vocational rehab consulting company] program at [vocational rehab consulting company]. She felt that she would be able to lift children because her shoulder was then functioning adequately.

Following further consultations between [Appellant's pain management specialist], [Appellant's doctor #3], [vocational rehab consulting company] and MPIC, an appointment was arranged for [the Appellant] to be assessed by [text deleted], a psychiatrist and the [text deleted]. His report, dated March 8th, 1996, negates any clinical depression but speaks, instead, of physical factors affecting the patient's psychological condition. He expressed concern that she had been seeing multiple caregivers from a variety of disciplines on an almost daily basis for a number of months, felt that her welcoming of this surfeit of professional attention was understandable due to a lack of attention during her own early childhood, but advised [the Appellant] that it was time to abandon the need for this type of gratification and move on. He also advised her of the pragmatic difficulties of having more than one caregiver, and felt that all caregivers involved in her rehabilitation should be aware of her propensity to split one caregiver against the other or others. [Appellant's psychiatrist] added that, since [the Appellant] was already seeing a very capable clinical psychologist in the person of [Appellant's psychologist], any psychotherapeutic

intervention that he might add would be redundant and would also set up two or more caregivers for further 'splitting'.

On April 10th, 1996, at a meeting between [Appellant's vocational rehab consultant] and [Appellant's doctor #3], the decision was made to discontinue [the Appellant's] program at [text deleted] and refer her to [rehab clinic] rehabilitation program, with a view to restoring her to the functional status of a full-time [text deleted] student and, when appropriate, to have her attend a functional restoration/work hardening program at [rehab clinic].

[The Appellant] was seen at [rehab clinic] for a multi-disciplinary screening assessment on April 30th, 1996. She participated in physiotherapy and occupational therapy assessments and the report of [rehab clinic], which is quite lengthy, may be summarized as follows:

(a) she had received physiotherapy from mid-February until mid-May 1995 and from early August 1995 until late April 1996 at [text deleted], with mixed results. She had received chiropractic treatment from [Appellant's chiropractor #2] from July 1995 until April 30th, 1996 and was still going to him at least once a week; she had received acupuncture treatment from [Appellant's pain management specialist] from December 1995 until mid-April 1996, with mild benefits;

(b) she only felt capable of light, domestic activities and of inactive leisure pursuits (knitting, playing scrabble or having coffee);

(c) all assessments were limited by reports of pain or 'give-way weakness'; [the Appellant] reported constant pain symptoms during all activities, particularly through the entire right arm, cervical area, right thigh and over the right hip, with occasional numbness in the right arm and hands; she perceived herself to be severely disabled;

(d) subjective complaints of pain and weakness in the right hip and lower extremities, with an antalgic gait pattern were noted, but none of them was consistent with present diagnoses and accident history; her performance on testing was consistently limited by subjective reports of symptoms making objective measure difficult to assess;

(e) [the Appellant's] use of two or more braces was not consistent with medical diagnosis.

The therapists completing the foregoing assessment recommended a multi-disciplinary, functional restoration program, consisting of one to two weeks of individual physiotherapy and conditioning classes three to five times weekly, two weeks of daily occupational therapy and, thereafter, a reassessment of both physical and functional abilities in order to determine the direction and continuation of the program. The goals of that program would be to assist in establishing a vocational goal for [the Appellant], to improve her physical and functional level through active rehabilitation, to identify and address behavioural components of current deficits and to provide education to help her in taking an active role in her own recovery and rehabilitation. They recommended the continued involvement of [the Appellant's] psychologist as an important factor in her rehabilitation, and medical confirmation of recommended use (or non-use) of braces. They felt that there were a number of potential barriers to physical rehabilitation including, but not limited to, [the Appellant's] self-assessment, her rating of her pain at 9 on a scale of 10, her report that her pain had changed her entire life, her criticism of previous therapists, her contention that her symptoms had worsened or, at best, continued in spite of all treatments to date, her dependency upon her fiancé/husband and her visit to hospital emergency room for pain medication.

On May 13th, 1996 [Appellant's pain management specialist] rendered a further report to [vocational rehab consulting company] in which he made the following points, inter alia:

- he again expressed concern over the number of caregivers and the frequency of treatments sought by [the Appellant];
- she was in the habit of taking chiropractic treatments several times per week and even having the chiropractor open up his office especially for her on some Sundays;
- she had re-entered physiotherapy at [text deleted] in mid-March although exercises there made her regress and she seemed to want [Appellant's pain management specialist] to undo what was being done at that clinic;
- two weeks after restarting physiotherapy at [text deleted], she appeared wearing two braces on her right wrist;
- on her next visit, she appeared wearing a soft neck collar;
- she failed to appear for her next scheduled visit, but her mother had phoned to say that [the Appellant] had gone to the [hospital #1] the previous night with severe pain;
- she had gone to see yet another, new caregiver, [Appellant's doctor #7], who arranged to see her on an urgent basis but, having done so, declined to treat her;
- [Appellant's pain management specialist], like other caregivers of [the Appellant], saw a pattern of splitting one therapist against another and getting urgent or special treatment for exacerbations of what seemed to be soft tissue pain.

A couple of weeks later, [the Appellant] was reporting improvements in her physical condition and an ability to tolerate more activities for longer periods. She had decreased the use of her wrist guard, her neck pain had decreased and range of motion increased; the swelling and pain in her right shoulder had also decreased although her right arm continued to spasm; she had been free from headaches for one and one-half weeks compared to her previous, daily migraines. She had been accepted into the [text deleted] program at [text deleted] and had started decreasing her

chiropractic appointments to one to two times weekly. She was still seeing [Appellant's psychologist] once per week; her treatments with [Appellant's pain management specialist] had been discontinued.

A report from [rehab clinic] on June 3rd noted that the Appellant had completed four weeks of her functional restoration program, with perfect attendance and punctuality and a positive attitude. A reassessment of her lifting ability had reflected more than double the capacity shown in her assessment of May 10th, and her therapists were optimistic that she could continue in functional restoration for a further four weeks, followed by formal testing.

2nd MVA

On June 10th, 1996 [the Appellant] was involved in a second motor vehicle accident, wherein she was a passenger in a vehicle that was rear-ended. She estimated the speed of the other vehicle at 8 to 10 kilometers per hour; the vehicle in which she was riding was stationary at a stop light. Her vehicle sustained no damage, other than a small mark on the rear bumper. There is some inconsistency in the evidence available to us, as to whether [the Appellant] was looking straight ahead or looking to the right at the time of the impact; when she saw [Appellant's chiropractor #2] on that same day, she completed a form stating that she was looking straight ahead, but as part of her sworn testimony she said she was looking right. In the event, by June 18th, 1996 [the Appellant] had reported feeling much better and close to the point that she had reached immediately prior to her second MVA if not, indeed, somewhat better.

However, [vocational rehab consulting company's] next report, dated July 19th, 1996, reflected the view of [Appellant's psychologist] that [the Appellant] had suffered an emotional setback

with her second MVA; [Appellant's psychologist] recommended that therapy at [vocational rehab consulting company] continue, but at a slower pace, and that her pain complaints be listened to carefully. The program was therefore adjusted, aerobic exercises were omitted and mobility pool classes were substituted. [The Appellant] started missing appointments, complaining of excessive pain; when she did appear, she was again wearing a cervical collar and wrist brace, exhibiting exaggerated pain behaviour not commensurate with any objective assessment findings. On the other hand, a report from [vocational rehab consulting company] of a reassessment on July 4th, 1996 reflects substantial improvement in [the Appellant's] performance abilities, despite her own self-perception as being severely disabled.

On August 14th, in discussion with [vocational rehab consulting company], [Appellant's doctor #3] reported the opinion of [Appellant's psychologist] that [the Appellant's] mental status had worsened as a result of her involvement in an active rehabilitation program; [Appellant's psychologist] felt that [the Appellant] was becoming increasingly depressed and that the pressure of rehabilitation was having a negative effect upon her physically by producing increased muscle spasms. [Appellant's doctor #3] therefore decided to discontinue the [vocational rehab consulting company] rehabilitation program and assess the result of that discontinuance thereafter. [The Appellant] was to continue her chiropractic treatments with [Appellant's chiropractor #2] and psychological counseling with [Appellant's psychologist]. [Appellant's doctor #3] also expressed the view that [the Appellant's] declared goal of a childcare worker was unrealistic, that [the Appellant] should stay home and abstain from working but that, perhaps at some future date, she would be able to work in a light or sedentary job. [Appellant's doctor #3] agreed that an independent psychiatric examination might well be in order.

A lengthy and comprehensive report from [Appellant's psychologist], forwarded to [vocational rehab consulting company] on September 29th, 1996, notes a number of Borderline Personality Disorder ('BPD') traits and the likelihood that those traits existed before her first motor vehicle accident. [Appellant's psychologist] felt that [the Appellant's] psychological condition would not prohibit her from continued participation in an active rehabilitation program, provided that program was within [the Appellant's] subjective level of tolerance. In other words, she should not be pushed beyond the level that she, herself, believed tolerable. The discontinuance of her [vocational rehab consulting company] program had, initially, seemed to produce a very encouraging result, with increased levels of happiness, absence of stress, more activities, better sleep and better interpersonal relationships. However, that improvement proved to be short lived since, by September 12th of 1996, [the Appellant] had again presented as enraged, egocentric, brittle, demanding and needy. There was no question that [the Appellant] was troubled by chronic pain syndrome which, in turn, inhibited her functional abilities. [Appellant's psychologist] felt that it was possible that [the Appellant] might then have reached maximum benefit from psychological input ("she has been given the tools, she now needs to implement them"), but [Appellant's psychologist] was obviously of the view that a carefully considered team approach to [the Appellant's] multiple problems was the only correct one.

Nerve conduction studies carried out in the Department of Clinical Neurophysiology at the [hospital #2] in [text deleted] on or about November 19th, 1996 produced a report of a "normal study with no suggestion of a right carpal tunnel syndrome" despite the fact that [the Appellant] complained that her fingers would curl up and she had some tingling in her fingertips. The entire examination was normal. At a meeting on November 5th, 1996 with [vocational rehab consulting company], [the Appellant] was complaining of tendonitis (amongst other matters) which she described as "worse than ever", resulting in an inability to write. The report of [vocational rehab

consulting company] from that meeting reflects that [the Appellant] was wearing her wrist guard and described her right hand as having been swollen and purple although no such signs were present at the actual meeting. She was able to write when asked to complete a form of consent and, although she claimed inability to move her right arm in certain positions, appeared well able to do so during that interview. She also reported having seen [text deleted], a hand surgeon, on October 16th of 1996, with a further referral from him to [text deleted], a plastic surgeon, for investigation of nerve damage in her right arm. The result of that nerve conduction test is noted above.

MPIC then consulted [text deleted], clinical psychologist, and [text deleted], the psychiatrist who had seen her in early March of 1996, asking each of them to complete a file review of [the Appellant's] post-MVA medical history to date. Each of them, in the course of providing full and specific answers to a number of questions put to them, agreed with [Appellant's psychologist] that it might well be time to move towards termination of psychological treatments, but that this would have to be carefully negotiated, of a time-limited nature and, in [MPIC's psychologist's] view, directly linked to a short term physical rehabilitation program. [Appellant's psychiatrist] felt that psychological therapy should be gradually terminated with perhaps occasional (e.g. monthly) sessions ongoing until [the Appellant] had become established as a [text deleted] student, if [Appellant's psychologist] concurred. He did not think it advisable for her to enter into treatment with another therapist. [MPIC's psychologist], while expressing the view that [Appellant's psychologist's] treatment of [the Appellant] had been quite appropriate, also expressed concern as to whether or not there had been enough emphasis placed on pain management and having [the Appellant] take more responsibility for both her emotional and her physical condition.

[The Appellant's] file was next referred to [text deleted], one of MPIC's medical consultants. His internal report, bearing date December 31st, 1996, carefully reviews her entire history and concludes that, while there is no physical reason why [the Appellant] could not return to the position of a full-time student as well as doing some part-time sedentary work, her level of impairment was the result of her psychological condition which had been diagnosed as a personality disorder. (We note, in passing, that although counsel for [the Appellant] submitted that this diagnosis had never, in fact, been made but that there had only been references to certain traits of Borderline Personality Disorder, a review of the entire file makes it pretty clear that, as [Appellant's psychiatrist] puts it, "[the Appellant] likely meets…..criteria for BPD (that is to say, Borderline Personality Disorder). It is equally clear that this condition is not a direct result of her motor vehicle accident".

[MPIC's doctor #1] also expressed concern with respect to two aspects of [the Appellant's] ongoing chiropractic treatment. First, he questioned the usefulness of that continuing treatment, which she had been receiving since shortly after her first accident in February of 1995 at an unusual frequency; secondly, he expressed concern that, despite requests from [vocational rehab consulting company] for information and a plan, [text deleted], [the Appellant's] chiropractor, had not responded, thus leaving an important gap in the available information about [the Appellant's] physical condition.

[MPIC's doctor #1] therefore agreed that a team meeting which, at that point, had been scheduled for a date in January 1997, was the most appropriate next step. The key issue to be addressed, he said, was how [the Appellant's] caregivers could manage appropriately [the Appellant's] psychological condition - i.e. her Borderline Personality Disorder. It should be noted at this juncture that, despite [Appellant's psychologist's] comment on September 24th,

1996 that the usefulness of psychological input might well have been reached, MPIC had continued to fund regular visits by [the Appellant] to [Appellant's psychologist's] clinic.

A further team meeting was held at [Appellant's psychologist's] office on January 27th, 1997. There were present at that meeting [the Appellant] and her husband, [Appellant's psychologist], [Appellant's doctor #3], [Appellant's chiropractor #2], [MPIC's doctor #1], [Appellant's vocational rehab consultant] of [vocational rehab consulting company], [text deleted] (MPIC's Case Manager) and [text deleted], [the Appellant's] lawyer. Amongst numerous other comments and conclusions, there appeared to be unanimity on two important points, at least: while comparatively gentle, physical rehabilitation should continue, a goal-oriented approach was needed, as opposed to a symptom-oriented one and, in any event, functional restoration was unlikely to be achieved to any noticeable extent unless and until [the Appellant's] psychological health had improved.

In a subsequent letter to [MPIC's doctor #1], [Appellant's psychologist] elaborated on these latter points. She said, in part:

> I am aware that rehab therapy promotes goal directed therapy. I think this needs to be paired with symptoms, response to treatment, psychological dynamics as well as the physical injury. It is my understanding…..that MPIC also holds the position……that physical rehab treatment alone is sometimes incomplete. You seem to be of the opinion that her mind needs mending before the body could respond. I agree. An essential component to the mending of mind is for her to experience a sense of safety with the rehab program, and to have the option to pace the treatment to fit her individuality. The result of going past her limit is psychological decompensation to a brittle state where her primitive defences appear. She needs choices, space and support. I do not think she is malingering or deliberately trying to be difficult. She is trying to recover and will recover to whatever level possible, if we give her the support she needs.

[Appellant's psychologist] concluded with a plea for clarification by MPIC of the Corporation's intent and the limitations that might exist to any benefits that MPIC could offer to [the Appellant].

On February 12th, [Appellant's case manager] of MPIC wrote to [Appellant's chiropractor #2] and [Appellant's psychologist], to tell them that MPIC would assume no responsibility for further treatments beyond February 26th of 1997. The reason given to [Appellant's chiropractor #2] was that there was no medical evidence of any underlying musculoskeletal disorder that had developed as a direct result of [the Appellant's] motor vehicle accident indicating the need for continuing chiropractic treatment. The reason advanced to [Appellant's psychologist] was MPIC's belief that, as [Appellant's case manager] put it, "MPI's responsibility to consider further payment of psychotherapy treatments has essentially achieved maximum results, in relation to any possible affect (sic) arising from the MVAs".

In an eight page letter to [the Appellant], also dated February 12th, 1997, [Appellant's case manager] summarized the payments that the insurer had made to or on behalf of [the Appellant], aggregating $60,752.00, explained how the quantum of her student lump sum indemnity had been arrived at, quoted from reports of [Appellant's vocational rehab consultant] and [Appellant's psychologist] and, apparently basing the decision largely upon [Appellant's psychologist's] earlier comment that "the usefulness of psychological input may well have been reached….." advised [the Appellant] of MPIC's decision to terminate any further benefits beyond February 26th, 1997.

[The Appellant] appealed from that decision to MPIC's Internal Review Officer (in this case, [text deleted]). [MPIC's Internal Review Officer], in addition to all of the material partly summarized above, had available to him the following additional reports.

Report of [MPIC's chiropractor] dated March 13th, 1997

[Text deleted] is a chiropractic consultant to MPIC. He had reviewed [the Appellant's] complete file up to that point although without any examination of [the Appellant]. His input had been sought for the limited purpose of assessing the appropriateness of continued chiropractic care. [MPIC's chiropractor] made reference to the Clinical Guidelines for Chiropractic Practice in Canada (1993) and, in particular, the statement in those guidelines, in the context of complicated cases, that:

> It is expected that patients will reach their maximum therapeutic benefit within six to sixteen weeks. To minimize the development of physician/patient dependence, treatment frequency should not exceed two visits per week after the first six weeks. An acute exacerbation may require more frequent care. Should pre-episode status not return, or additional improvement not be forthcoming, maximum therapeutic benefit should be considered to have been reached.
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> Passive/active care: a shift in emphasis from passive to active care is required, when improvement warrants, so as to reduce disability, practitioner dependence and chronicity.

[MPIC's chiropractor] concluded that [Appellant's chiropractor #2's] treatment program had not recognized lack of progress and had, indeed, fostered in [the Appellant] a dependency on his treatment to which she was vulnerable by her pre-existing psychological state. [MPIC's chiropractor] noted that [Appellant's chiropractor #2's] treatment had been based, in large part, upon subluxation correction. He noted that [Appellant's chiropractor #2] bases the need for ongoing treatment on [the Appellant's] spinal instability. However, said [MPIC's chiropractor], if, in fact, [the Appellant] has instability of the vertebral motion segments of her injured spinal

regions, then any therapy that would further mobilize these area, such as spinal manipulations or adjustments, would be not only inadvisable and non-therapeutic but contraindicated.

[MPIC's chiropractor] concluded that further chiropractic care was of doubtful benefit to [the Appellant]. "It has not been of benefit, and this is demonstrable based on the contents of this file, and it is possible that the approach taken by [Appellant's chiropractor #2] has fostered increased dependence of [the Appellant] on passive care. It is my recommendation that chiropractic treatment be discontinued immediately."

Report of [MPIC's doctor #2] of April 3rd, 1997

[MPIC's doctor #2] is Medical Director of the Claims Services Department at MPIC and he, also, was asked to review the documentation on file to provide an opinion as to the need for continuing income replacement indemnity benefits for [the Appellant]. [MPIC's doctor #2] noted that [the Appellant] appeared to have Borderline Personality Disorder ('BPD'), a Grade 2 Whiplash Associated Disorder (typically requiring from one to three weeks of activity limitation), lateral epicondylitis, myofascial pain and chronic pain behaviour syndrome. [MPIC's doctor #2] expressed the view that [the Appellant] could not be held responsible for having an underlying psychological condition making rehabilitation more difficult; in [MPIC's doctor #2's] view, that was still the Corporation's responsibility. However, he felt there was little evidence of objective physical impairment and that it was [the Appellant's] psychological problems that were prohibiting her from working. He suggested an up-to-date, reliable, physical examination and ongoing, short-term psychotherapy to help [the Appellant] deal with her pain in a more constructive fashion. In patients with BPD, [MPIC's doctor #2] felt that long-term psychotherapy would probably not have a good prognosis.

Report of [Appellant's shoulder surgeon] of May 7th, 1997

[Text deleted], who has particular expertise in the field of shoulder injury, examined [the Appellant] on April 10th, 1997 and, after describing her several ranges of motion, expressed the view that his findings would not preclude [the Appellant] from returning to university as a student with her arm at her side, nor from returning to any sedentary type of work. He said "As long as her arm is not elevated and not carrying a lot of weight I do not think there should be any functional restriction to work". He diagnosed rotator cuff pain and dysfunction. He suggested that, for the sake of completeness, an arthroscopic examination of [the Appellant's] right shoulder to rule out mechanic problems would be in order although he felt that there was a less than 50% chance that there was an actual, mechanical problem.

Report of [Appellant's doctor #3] of May 22nd, 1997

[Appellant's doctor #3] confirmed his "standing diagnosis" of [the Appellant], that she had chronic right shoulder and neck myofascial pain syndrome related causally to her motor vehicle accident. Specific treatment had focused on directing [the Appellant] to the suggested therapists and utilizing prescription medication, primarily Amitriptyline as an analgesic and anti-depressant. He had also prescribed anti-inflammatory drugs as needed.

More recently, [Appellant's doctor #3] reported, [the Appellant] had developed right arm and hand symptoms which had gone unexplained up to the date of his letter. [The Appellant] had been seen by [Appellant's hand surgeon] who had expressed concern about a wasted upper arm with clawing of her right hand. [Appellant's hand surgeon] had referred her to [text deleted], a

plastic surgeon from whom there is no report; [Appellant's plastic surgeon], for his part, had referred [the Appellant] to [Appellant's shoulder surgeon], whose report is noted above.

[Appellant's doctor #3's] prognosis for [the Appellant] was guarded. He believed she had chronic myofascial pain and some objective symptoms which continued to defy explanation. He felt that [the Appellant's] problem would persist, was chronic and would not improve.

Finally, said [Appellant's doctor #3], he believed that [the Appellant] needed to be continually assessed by occupational therapy and physiotherapy; she needed ongoing reassessment of her functional capacity and that her condition was such that she was permanently disabled from repeated or heavy usage of her right shoulder/neck and arm.

Reports of [Appellant's internal medicine specialist] of June 23rd, July 7th and September 11th, 1997

[Text deleted] is a specialist in internal medicine with the [text deleted], to whom [the Appellant] was referred by [Appellant's doctor #3]. He noted that, apart from a history of lifelong asthma and recurrent ganglion cysts which she had had excised in the past, [the Appellant's] pre-MVA history was otherwise unremarkable. [The Appellant] had reported to [Appellant's internal medicine specialist] that, since her accidents, she had sustained ongoing problems with total body pain including neck, back, elbows (right greater than the left), fingers, hands, wrists, shoulders, hips and knees. She had also been having problems with her right forearm tendonitis and, more recently, had been troubled by left forearm tendonitis. She had complained of extreme fatigue and memory impairment. During the preceding two months she had complained of ongoing daily temperatures ranging from 37.5 to 37.8 degrees Celsius, with temperatures being

worse at night. She also complained of anorexia although her weight had actually been stable. She had had wisdom teeth extracted about a month previously but her heightened temperatures had started one month prior to that. [Appellant's internal medicine specialist], after describing a review of [the Appellant] systems, all with normal results other than symptoms of recurrent, sharp, bilateral chest pains, also described numerous laboratory investigations that he had carried out. He concluded:

> The patient would appear to have fibromyalgia presumably related to her previous motor vehicle accidents. In addition she also has some elements which would be suggestive of chronic fatigue syndrome. There are no specific indications at the present time that she has an underlying infectious or inflammatory disorder and I would doubt whether she has an occult malignancy. Nonetheless, we will arrange for her to have an abdominal CT Scan and some of her lab work has been repeated.

In a letter of July 7th, 1997 addressed to [text deleted], counsel for [the Appellant], [Appellant's internal medicine specialist] reiterated that [the Appellant] showed no evidence of any rheumatic disorder. He went on to say:

> I would certainly agree that she does have ongoing problems with fibromyalgia.
>
> I would agree that physiotherapy, as well as mild to moderate analgesia, might be of ongoing benefit to her.
>
> In view of the long standing nature of her symptoms, I would not anticipate an immediate recovery. This may in fact be a chronic ongoing problem for her.

In a final, followup letter to [Appellant's doctor #3] of September 11th, [Appellant's internal medicine specialist] noted that he had had [the Appellant] evaluated by [text deleted] (specialist in infectious diseases) and [text deleted] (rheumatologist) who had concurred in his diagnosis of fibromyalgia and chronic fatigue syndrome. [Appellant's internal medicine specialist] reiterated all of the tests that he had arranged for [the Appellant], noting that her abdominal CT Scan was within normal limits and had ruled out any occult malignancy. He had suggested to [the

Appellant] that she get some books on fibromyalgia and chronic fatigue syndrome from the library to educate herself on the disorder. He did not feel that there was much more that [the Appellant] could be offered, particularly since she felt that physiotherapy had not been of any benefit to her.

Report of [Appellant's rheumatologist] of September 8th, 1997

[Appellant's rheumatologist] confirmed the diagnosis of fibromyalgia, noting that [the Appellant] had thirteen out of a potential eighteen fibromyalgia tenderpoints as well as other indices of that diagnosis. Saying that he could not yet rule out a right shoulder rotator cuff tear, he had ordered a magnetic resonance imaging of that shoulder. For the time being, he recommended certain medications and encouraged [the Appellant] to be as active as possible and to consider aquacise. He felt that she would also benefit from a generalized stretching program on a daily basis. An X-ray of [the Appellant] cervical spine disclosed no abnormalities.

Report from [MPIC's doctor #2] and [MPIC's doctor #3] of September 25th, 1997

This was an interdepartmental memorandum prepared by [MPIC's doctor #2] and [MPIC's doctor #3] for [text deleted], the Internal Review Officer of MPIC, in light of the reports that had come in since [MPIC's doctor #2's] earlier review of April 3rd, 1997. Their report notes that it is unclear as to who made the diagnosis of fibromyalgia referred to in [Appellant's internal medicine specialist's] letter, particularly since [the Appellant] had been examined previously by [Appellant's doctor #5], an expert in that field, who had made no such diagnosis. Patently, [MPIC's doctor #2] and [MPIC's doctor #3] did not have [Appellant's rheumatologist's] letter of September 8th in front of them when dictating their views on September 25th, since [Appellant's

rheumatologist's] diagnosis is clear and unequivocal. It has to be said, however, that this Commission has difficulty determining how a diagnosis of fibromyalgia can be made of any patient who complains of tenderpoints at just about every conceivable portion of her body including, but not limited to, the specific tenderpoints used by a diagnostician in attempting to discover the existence of fibromyalgia syndrome.

[MPIC's doctor #2] and [MPIC's doctor #3] also point to [Appellant's chiropractor #2's] concern for [the Appellant's] ongoing use of her right arm, wrist and hand, specifically with respect to writing, when she is described by [Appellant's pain management specialist] as being left-hand dominant.

Once again, [MPIC's doctor #2's] view was that there were no physical signs of impairment and, therefore, no resultant disability in [the Appellant's] case. He could not recommend any further physical treatment since [the Appellant] had already received multiple therapies with no change in symptoms lately. Treatment might actually perpetuate or increase her problems, he felt. In sum, he recommended short-term psychotherapy to help [the Appellant] deal with her pain in a more constructive fashion.

Internal Review Officer's Decision

Based upon all of the foregoing material, [MPIC's Internal Review Officer] formed the conclusion that the treatments given to [the Appellant] over the intervening years had been effective, from a physical standpoint, in restoring her level of function to the point at which she now had no measurable degree of impairment or disability. He agreed with [MPIC's doctor #2] that [the Appellant] was not responsible for having a pre-existing, underlying, psychological

condition rendering rehabilitation more difficult but, by the same token, he was not convinced that MPIC should have to pay ongoing income replacement indemnity to a victim who, while physically capable of doing what she was capable of doing before her accidents, was still hampered by psychological traits that were not caused, nor made worse, by those accidents.

[MPIC's Internal Review Officer] therefore declined to order the reinstatement of [the Appellant's] income replacement indemnity.

Referring to [MPIC's doctor #2's] recommendations regarding short-term psychotherapy, [MPIC's Internal Review Officer] effectively referred that aspect of [the Appellant's] treatment back to [text deleted], her Case Manager, to "deal appropriately with a substantiated request for funding if and when it is submitted". [MPIC's Internal Review Officer] presumably used the latter phrase because, as he noted earlier in his decision, no plan for short-term psychotherapy had been put forward for MPIC to consider.

[The Appellant] appealed to this Commission from [MPIC's Internal Review Officer]'s decision, by way of a notice bearing date February 13th, 1998.

(Since [the Appellant's] Notice of Appeal to this Commission raised a new issue, namely her entitlement to "house care expenses" under Sections 131-137 of the Act, we referred that aspect of her appeal back to her Adjuster. The Adjuster denied that claim, as did MPIC's Internal Review Officer, on the ground that there was no evidence to support it. No evidence in that context was adduced before us, either, and that claim was not pursued when the appeal came before this Commission.)

Evidence Supplied After February 13th, 1998

(i) **Report from [Appellant's psychologist] of April 7th, 1998.**

[Appellant's psychologist], in a report to counsel for [the Appellant], said that she had met with [the Appellant] on March 3rd, 1998 for the first time since February 19th, 1997. While her patient looked frail and sick, psychologically she was in a good mood, reported coping well with life's difficulties and reasonably happy. Her relationships with her husband and her mother were both going well, the psychological brittleness and anger that had previously been evident were gone. [Appellant's psychologist's] letter certainly implies that [the Appellant's] previous traits of Borderline Personality Disorder had been resolved since, in [Appellant's psychologist's] opinion, "[The Appellant] does not need any further psychological treatment. She has made good use of our time together, understands herself well, has learned how to manage the chronic pain and is using the insights and coping techniques in her daily life. There is nothing psychological that is holding her back from a more complete recovery. [The Appellant] is managing well with difficult medical conditions."

[Appellant's psychologist] reports that

> I saw a frail young woman with fibromyalgia and an unusual condition called chronic chlomydial (sic) infection. It would appear that having these conditions diagnosed, explained and treated had helped her settle psychologically.

There is no indication in [Appellant's psychologist's] letter of how she arrived at the diagnosis of "chronic clomydial infection", and this is the first reference that we can find to it in the entire file and, since [Appellant's psychologist] is not a physician, we have to assume that this is something she was told by [the Appellant] who, undoubtedly, intended to refer to 'chronic chlamydial infection'.

(ii) **Further report from [MPIC's doctor #2] and [MPIC's doctor #3], of July 3rd, 1998**

[MPIC's doctor #2] and [MPIC's doctor #3], after completing a further review of [the Appellant's] entire file, conclude that [the Appellant] had a mildly restricted range of motion of her cervical spine and decreased range of motion of her right shoulder, with mild weakness of her right shoulder abductors. This, they felt, could limit vocational and recreational involvement to a mild extent. They also concluded from [Appellant's psychologist's] letter, as does this Commission, that [the Appellant's] previous barrier to rehabilitation, in the form of Borderline Personality Disorder, had resolved and that the various physical therapies [the Appellant] had undergone had not changed her symptomatology which appeared primarily related to her diagnosis of fibromyalgia syndrome. The relationship between the syndrome and traumatic events had not been established. They also offered the following comment:

> It is known that, despite an increase in symptomatology that may occur with employment or work, such activity does not worsen the course of the syndrome. Remaining off work has many detrimental side effects and ramifications related to social isolation, decreased financial control, decreased self-esteem and lack of sense of productivity. Benefits of returning to work or school would include social interaction, increased sense of financial control, improved self-esteem and sense of productivity, along with a maintenance of a physical activity level.

Although [Appellant's doctor #6] and [Appellant's chiropractor #2] had both labeled [the Appellant] as 'disabled', [Appellant's doctor #3] had supported the view of [Appellant's rheumatologist] that there was no literature to support any treatments for fibromyalgia syndrome that would improve the symptomatology other than regular exercise, and that [the Appellant] should remain as active as possible and consider aquacise as a form of activity. Although [Appellant's chiropractor #2] had mentioned the possibility of secondary or post-traumatic osteoarthritis, there was no clinical evidence to support that suggestion.

(iii) **Literature**

Counsel for both [the Appellant] and MPIC have provided this Commission with abundant literature on the subject of fibromyalgia syndrome from a variety of professional journals, for which we are indebted to them.

(iv) **Report of [independent chiropractor] of August 17th, 1998**

[The Appellant] was referred, under Section 144(2) of the MPIC Act, to [independent chiropractor] for an examination and assessment. [Independent chiropractor's] seventeen page report describes, in some detail, [the Appellant's] medical history both before and after her motor vehicle accidents, as well as the results of his in-depth examination of [the Appellant]. He concluded that:

(a) [The Appellant] has long since reached maximum therapeutic benefit from chiropractic treatments and he could see no reason to continue them;

(b) he did not believe that [the Appellant] was physically disabled with regards to being a student. However, her chronic pain syndrome represented a handicap, as opposed to a physical impairment, and [independent chiropractor] felt that this should be addressed by an independent psychological or psychiatric evaluation;

(c) he felt that [the Appellant's] prognosis was 'guarded', but that it was, as well, largely dependent upon [the Appellant] herself. There was always the option of doing nothing and allowing [the Appellant] to gravitate to that level of functioning that was consistent with her perceived level of pain. However, he hoped that [the Appellant] would seek further psychological care that might enable her to proceed in a time-framed function-based program that would promote and focus upon her abilities;

(d) while he would encourage [the Appellant] to exercise, he felt that a formal rehabilitation or reconditioning program would, at that point, likely be a failure;

(e) despite [Appellant's psychologist's] belief that there was no psychological factor holding back [the Appellant], [independent chiropractor] was nonetheless was of the opinion that further psychological intervention was indicated.

(v) **Report of [Appellant's infectious diseases specialist] of November 13th, 1998**

In reply to an inquiry from this Commission, [text deleted], a consultant in infectious diseases and internal medicine with the [text deleted] Clinic, responded to us on November 13th, 1998. In light of [MPIC's doctor #2's] remark that chronic chlamydial infection, if present, might account for many of [the Appellant's] complaints, we had asked [infectious diseases specialist] for a report, in narrative form, detailing his diagnosis, treatment and prognosis of [the Appellant] and, in particular, the nature of any infection from which she might have been suffering, the date it was contracted (if known) and its probable effects upon [the Appellant's] general condition and her ability to function.

[Infectious diseases specialist's] report, if we understand it correctly, appears to be telling us that he had not really diagnosed that infection but had, rather, merely told [the Appellant] that, as he puts it:

> A subgroup of chronic fatigue syndrome was found to have high titre of chlamydial pneumonia…..a bacteria which recently has been discovered to be positive in a certain percentage of the population of patients with chronic fatigue syndrome…..There still is not any relationship between cause and effect being established, and I cannot give you any substantiated reference to back up this theory. After going through and ruling out all the other possibilities, including collagen vascular disease, lupus or rheumatoid-arthritis-like picture, we can to the conclusion that most likely her problems were related to a post-trauma injury caused by musculoskeletal strain or sprain which eventually ends in a picture-like myofascial pain syndrome, which is causing her sleep disorder, chronic fatigue and tiredness.
>
> Dealing with these type (sic) of patients is extremely difficult and requires lots of rehabilitation modalities, physiotherapy, pain killers and medication to improve the sleep, which we have done for her since I was involved with her care.
>
> The dilemma with chlamydial infection is that there is no proven efficacy that any antibiotic therapy for that organism would have any effect on her course of chronic myofascial pain syndrome. These things were of interest to her and she wanted more

> information. I as a physician had to give her any information that I had available to me, regardless if it was going to help with her condition of myofascial pain or not.

In other words, he had merely told her of the occasional presence of clamydial infection as a sub-group of chronic fatigue syndrome and, since that had aroused her interest, had given her some more information.

Oral Testimony

The hearing of [the Appellant's] appeal spread over several days, primarily to accommodate the timetables of the various caregivers who were called upon to testify and, as well, to accommodate counsel. Much of the testimony merely confirmed or reiterated various aspects of written reports that were already on file. To the extent that the oral testimony duplicates opinions and comments already embodied in these reasons, we shall omit it.

[The Appellant]

[The Appellant], after testifying about her accidents and her immediate, post-MVA history, testified that she was still wearing a splint to prevent the reappearance of wrist cysts on the ganglion on top of her right wrist and was also wearing a lapstrap which she described as a kind of shock absorber, consisting of small pockets of gel within a bandage, to cushion any impact to her arm which otherwise experiences 'electrical types' of shock up her arm. She also complained of a pinched nerve in her right hip. She was seeing [Appellant's chiropractor #2] about three times per week. He was treating her for spinal subluxations and to ease pinched nerves in the base of her skull, her right scapula, both elbows, both hips but, in particular, her right hip. She had taken no physiotherapy since leaving [rehab clinic]. She gets out as much as she can; she

uses a treadmill and, as well, rubber bands that she uses to exercise her shoulder and her hands. She did not think that she had ever been diagnosed with Borderline Personality Disorder, but [Appellant's psychologist] had told her that chronic pain can sometimes cause that disorder.

[The Appellant], when asked what she wanted this Commission to order MPIC to do for her, said that she wanted another opinion respecting her shoulder, she wanted to see another specialist respecting her neck and back since that was keeping her from sitting or working, she sought extended chiropractic and a return to extended physiotherapy. While [the Appellant] did not say so herself, her counsel made it clear that she also sought the reinstatement of her income replacement indemnity from the date when it was discontinued in February of 1997.

[The Appellant] also testified that she had been told by [Appellant's doctor #4] and others that her hand problem was the direct result of her shoulder damage and a pinched nerve there. She explained that she had been shifting from first to second gear at the time of her first motor vehicle accident, when her body moved forward and to the right in her vehicle. In her second motor accident, she had been a passenger with her seatbelt on and that there was no apparent damage to her car other than a small mark on the rubber bumper at the rear. She said "I had no real shoulder problem before my second accident". She also testified that [Appellant's doctor #3] and her physiotherapist at [text deleted] Clinic had told her that her wrist cysts were caused by the motor vehicle accidents. However, documentary evidence seems to indicate that she had suffered from these for some time prior to her first accident. [The Appellant] added that these cysts were fixed by minor surgery - local anesthetic followed by a needle to remove fluid.

She had been accepted into the [text deleted] program at [text deleted] but she had not started in the program because she thought she would be facing some surgery for her shoulder.

She had not done any aquacises because she could not afford to do so.

Her "pinched nerve" in her right hip had started some time after her first accident; it had been made worse by her second accident which had also precipitated the "pinched nerve" in her left hip.

[Appellant's chiropractor #2]

[Appellant's chiropractor #2], who had first seen [the Appellant] some eight months after her first accident, testified as to his belief that, in her first accident, [the Appellant's] vehicle had been broadsided from the left and that she would have been thrown from side to side, damaging her lower back and mid dorsal area. When hit from the left, he said, the body is thrown first to the left and then rebounds towards the right.

He had been treating [the Appellant] for subluxations for her upper and lower cervical spine, mid-dorsal, upper and lower lumbar spine. He had seen her three times weekly until the second accident, by which time she had seemed to be improving, albeit very slowly. He estimated a 30 to 40% recovery by that point, with continued but less severe pain. The questionnaire filled out by [the Appellant] for [Appellant's chiropractor #2] on the day of her second accident, June 10th, 1996, indicates that, at the time of that accident, she was looking straight ahead. However, [Appellant's chiropractor #2] acknowledged that much of his evidence had been based upon the proposition that her head was turned to the right at the time of impact.

He had continued to treat [the Appellant] at a frequency of two to three times per week and described her as "the most complicated case I've ever seen". [Appellant's chiropractor #2] took strenuous issue with many facets of the reports of [independent chiropractor] and[MPIC's chiropractor]. He testified that he had found serious neurological compromise, including Grade 4 reflex in her right arm and Grade 4 reflex in her Achilles tendon. He agreed that "Reflexes don't come any stronger than Grade 4". He felt that [the Appellant's] loss of muscle strength was due in part to both neurological and musculoskeletal involvement, but he had not referred her to a neurologist because "Chiropractors do handle those kinds of case". He did not agree that his findings indicated grave problems that posed possible serious danger to [the Appellant], although he agreed that Grade 3 muscle strain implied an inability to move against anything more than minimal resistance.

He had given [the Appellant] no grip strength tests and had not attempted to measure her range of motion at his first examination. He agreed with the suggestion from counsel for MPIC that [the Appellant's] neurologic and orthopaedic signs by the time of her second accident were much the same, if not actually worse, than they had been after her first accident. The second accident had not, in [Appellant's chiropractor #2's] view, created any new injuries; it has simply exacerbated or intensified some of her earlier symptoms. He agreed that his report of February 12th, 1998 described [the Appellant] as being in worse condition than in his first report. Her range of motion was still reduced, similar to that reflected in his first report. Her neurological signs had cleared up before June of 1996 but her orthopaedic tests produced much the same results as had been the case prior to her second accident; he had not documented those tests either before or after the second accident. By February of 1998, he agreed, the earlier muscular weaknesses of her wrist and shoulder had still not resolved, although that was not reflected in his February 12th, 1998 report, either. [Appellant's chiropractor #2] also agreed that, although he

had made reference in his report of February 12th, 1998 to crepitation and shoulder locking, which he ascribed to [the Appellant's] first accident, those problems had never been mentioned in any earlier reports and were surfacing for the first time some three years after the first accident. His clinical notes had made no mention of crepitus although his notes of April 2nd, 1996 had noted the shoulder locking.

[Appellant's chiropractor #2] felt that [the Appellant] had improved 'to a limited degree' since his report of February 12th, 1998; he was still seeing her a couple of times a week, being of the view that she needed his treatment in order to remain functional. He did not agree that she had chronic pain syndrome. He was not familiar with that syndrome, he said, but he believed that her complaints stemmed from physiological factors, such as subluxations - of which she had five that were now hypomobile. We note, in passing, that in his examination-in-chief [Appellant's chiropractor #2] had testified that these subluxations were hypermobile because the ligaments were damaged. He explained that discrepancy by testifying that these subluxations had started off as hypermobile but, over time, had become hypomobile. There still some instability or hypermobility in some isolated area, including her shoulder, but overall he felt that her spine was hypomobile.

It is, perhaps, noteworthy that the reports of [Appellant's chiropractor #2] during the weeks and months prior to [the Appellant's] second accident indicate that he was treating her for migraine headaches.

[Appellant's occupational therapist]

[Appellant's occupational therapist] was an occupational therapist with [rehab clinic] at all material times. She described numerous forms of symptom magnification on the part of [the

Appellant] and, simply put, her evidence confirmed that, with the exception of a few, short-term setbacks, [the Appellant's] observed, functional capabilities had improved quite materially but that [the Appellant], herself, was unwilling to accept that fact. [Appellant's occupational therapist] did not suggest that [the Appellant] was malingering and she agreed that [the Appellant] was receiving mixed messages from her various caregivers, some of whom obviously felt that reasonable, achievable goals had been established and others who felt that those goals could never be accomplished. Some caregivers were apparently prescribing the use of braces and a soft cervical collar, while others felt that those devices were likely to do more harm than good, if only by emphasizing to the patient her perceived, but probably non-existent, degree of disability or impairment. [Appellant's occupational therapist] did not know that [the Appellant] had been diagnosed with fibromyalgia syndrome but testified that, even if that had been the case, it would not account for the incongruity between [the Appellant's] objective signs and the extreme nature of her complaints. [The Appellant's] second accident had certainly produced a setback but, from [Appellant's occupational therapist's] perspective, [the Appellant] had regained her prior condition within a week or two thereafter. The advice that [the Appellant] was receiving from [Appellant's psychologist], that she could never return to the [text deleted] program, was certain to have had a negative effect upon [the Appellant's] outlook. However, [Appellant's occupational therapist] acknowledged that [Appellant's psychologist's] opinion had not been based merely on physical factors; there were a lot of psychological factors involved.

[Appellant's physiotherapist #1]

[Appellant's physiotherapist #1] is a physiotherapist working with [rehab clinic], [text deleted]. She had somewhat limited contact with [the Appellant] and her evidence was, therefore, brief. She had given [the Appellant] individual therapy on two occasions and had supervised her

participation in light weight classes as part of her functional restoration program from time to time. She remembered [the Appellant] complaining of pain in her arm and her neck. She testified that "We don't hold someone back from a given program just because of pain. Sometimes, however, because we also listen to what a patient tells us, it is desirable to give the patient a little more time before adding a new component to that program". In that context, said [Appellant's physiotherapist #1], she had suggested to [Appellant's occupational therapist] on August 2nd that the start of the lumbar stabilization portion of [the Appellant's] program be deferred until August 12th of 1996, presumably because of complaints of pain respecting the program in which [the Appellant] was already engaged. The Appellant's shoulder rotator muscles were also very tight.

[Appellant's physiotherapist #2]

[Appellant's physiotherapist #2] was a physiotherapist at [rehab clinic] from March of 1996 until December of 1997. Much of her evidence was confirmatory of the information already on file. She testified that, while she was familiar with fibromyalgia syndrome, she was not aware that [the Appellant] had been diagnosed with that syndrome. Had she known of it, given that the main form of physiotherapy applicable to that syndrome consisted of stretching and strengthening exercises, she did not feel that the program at [rehab clinic] would have changed very much.

At a meeting on July 23rd, 1996, [the Appellant] had complained that her caregivers were not listening carefully enough to her complaints of pain. [Appellant's physiotherapist #2] testified that she had explained to [the Appellant] that her pain behaviour was inconsistent - sometimes she would be very vocal and complaining, so when those complaints were absent her caregivers

concluded that she was able to manage quite well and with minimal pain. She had not perceived a major problem with [the Appellant's] right shoulder; it seemed to her more like a mild form of tendonitis. [The Appellant] had been able to lift her right arm all the way up and, although that movement was different from putting a 'scrunchy' in the back of the hair (an ability denied by [the Appellant]), essentially the same musculature was marshalled.

[MPIC's doctor #2]

[MPIC's doctor #2] testified that the most important forms of treatment for fibromyalgia syndrome required eight hours of refreshing sleep per night, ample exercise - especially aerobic exercise - and psychological counseling. Advice given to a fibromyalgia syndrome patient to rest was inappropriate. The syndrome is essentially a self-reporting condition. In assessing impairment, [MPIC's doctor #2] found that [the Appellant] does, indeed, suffer from a measure of impairment and there was a good possibility of permanent impairment related to her neck, shoulders and back. Since two years had elapsed since her last accident and it was therefore necessary to look at possible occupations, she would need a functional capacity evaluation.

[MPIC's doctor #2's] main concern was with respect to [the Appellant's] right shoulder and, in particular, to her range of motion and overhead movement.

A wrist brace was not usually appropriate in the absence of bony or ligamentous damage; a soft cervical collar was contra-indicated, leading to increased stiffness and increased weakness.

Treatment for fibromyalgia syndrome called for very supportive care, with education emphasizing that continued pain does not necessarily mean the condition is getting worse, maximum possible involvement in the workplace and careful, focused attention to the patient's depression. Treatment directed solely to muscular restoration was destined to fail, but treatment should nevertheless include stretching and then strengthening of the muscle. He agreed with [Appellant's doctor #5] that the passive kinds of therapy that [the Appellant] had been receiving from [Appellant's chiropractor #2] was contra-indicated. A Grade 2 Whiplash Associated Disorder normally allows the patient to return to work within a week or two and calls for continued physical activity. "Abnormal illness behaviour" signifies an obvious discrepancy between the overt reaction of a patient and the actual, objective tissue damage. That behaviour often calls for referral to a psychologist for help in dealing with pain.

[MPIC's doctor #2], emphasizing that he is far from 'anti-chiropractor' - he testified that he, personally, attends for chiropractic treatment and refers patients to chiropractors from time to time - agreed that spinal manipulation therapy for neck, mid-back and lower back pain can often be of value. However, he testified, although a chiropractor can be of help to a fibromyalgia symptom patient in a number of ways, he did not believe spinal manipulation could help. Referring specifically to [Appellant's chiropractor #2's] reports, [MPIC's doctor #2] said that, while he did not doubt [Appellant's chiropractor #2's] qualifications, he had some serious concerns in that context. Some of those concerns may be summarized as follows:

(a) after [the Appellant's] second MVA, [text deleted], a nationally recognized shoulder specialist, found full range of motion in [the Appellant's] right shoulder, whereas [Appellant's chiropractor #2] merely speaks of 'limitation' without indicating the extent of it;

(b) at the time of [MPIC's doctor #2's] first review of [the Appellant's] file, she had been treated by [Appellant's chiropractor #2] in excess of 250 times. She had some ligamentous 'slackness', for which spinal manipulative therapy was a contra-indication, as was almost any form of passive therapy;

(c) [Appellant's chiropractor #2] speaks of subluxations which, in the normal course, should be fixed within one or two treatments and, in any event, were not normally associated with nor related to fibromyalgia syndrome. [MPIC's doctor #2] added, in this context, that 'myalgia' is a muscle ache; it was impossible to tell whether a subluxation or a myalgia had been traumatically induced;

(d) the opinion of [Appellant's shoulder surgeon] was, in [MPIC's doctor #2's] view, to be preferred over that of [Appellant's chiropractor #2] with respect to [the Appellant's] shoulder;

(e) fibromyalgia is not pinched nerves nor subluxations. [Appellant's chiropractor #2] was not, so far as could be told from his reports, treating [the Appellant] for fibromyalgia; his correspondence indicates that he was addressing what he called 'chronic subluxations';

(f) there was no documented evidence of radiculopathy or so-called 'pinched nerve'. When [Appellant's chiropractor #2] refers to nerve root compression in describing his diagnosis, he is writing of a 'pinched nerve', but there was no evidence of sensory loss nor anything else to support that diagnosis. [MPIC's doctor #2] felt that [Appellant's chiropractor #2's] diagnosis stood alone, amongst all of [the Appellant's] caregivers;

(g) [MPIC's doctor #2] emphasized that he knew of no literature, no studies, no research of any kind that could justify extending [the Appellant's] chiropractic treatments beyond the point at which payment for those treatments had been terminated by MPIC.

With respect to [the Appellant's] apparent wrist problem, [MPIC's doctor #2] testified that a ganglion cyst is an outcropping from the synovium, usually caused by repetitive motion. There was evidence on [the Appellant's] file of surgery for ganglion cysts predating her first accident. Cysts of that kind can, to a very minor extent, limit full function of the wrist, but only minimally. Ganglion cysts can be caused by trauma, although [MPIC's doctor #2] commented that he had never, personally, seen it. The usual treatment for them was surgical removal under local anesthetic. Since [the Appellant's] ganglion cysts did not seem to be mentioned in any early, post-MVA reports, and since she had apparently suffered from them prior to her first accident, he felt morally certain that the cysts of which she complained were not related to either of her accidents.

[MPIC's doctor #2] expressed the opinion that [the Appellant] needed psychological help in understanding her pain; it was imperative that she discontinue all passive therapy. He could see no evidence that anything other than her motor vehicle accidents caused her neck and shoulder problems, and what was needed was a program to be developed for her, involving a small team consisting of a rehabilitation psychologist, a physiatrist and a kind, compassionate, reasonable physiotherapist. [MPIC's doctor #2] reiterated the view that, before any physical modalities would be likely to achieve much for [the Appellant], her principal need was for some intensive counseling by a pain psychologist, to be followed by work with a physiatrist and physiotherapist.

[Independent chiropractor]

[Independent chiropractor], a chiropractic consultant for MPIC and in practice since 1978, described his examination of [the Appellant] and his resultant assessment. He testified that no swelling nor any discolouration had been detected. [the Appellant] had presented with wrist and

elbow supports which he had removed in order to examine the limb. He had concluded that they were both unnecessary since there was no evidence of any lesion. He had observed no muscle spasms although he had seen some hypertonicity - that is, tightness of muscles - in [the Appellant's] right shoulderblade area.

[The Appellant] had displayed a quivering of her right arm and knee which, said [independent chiropractor], he could not explain in physical terms. Muscle fasciculation can sometimes contract involuntarily where there is a local radiculopathy, but he found no evidence of C6 radiculopathy, which is the situs where he would have expected to find a lower neuron lesion. He had found no evidence of any nerve root compression or entrapment.

He described a partially frozen shoulder as a 'painful, stiff shoulder, not actually due to the joint itself but to the musculature and ligamentous tissue around the joint, usually caused by lack of use or protective behaviour'.

[Independent chiropractor] emphasized that a chiropractor will adjust hypomobile segments of the spine but would leave hypermobile segments alone. He pointed out that the object of chiropractic adjustments was to induce greater mobility into a joint; inducing even more mobility into an already hypermobile joint was harmful.

Chiropractors do treat people with fibromyalgia syndrome, said [independent chiropractor], the purpose of that treatment being palliative, focusing on lifestyle changes, exercises, sleep patterns, et cetera; a chiropractor can only treat symptoms that appear to limit function and are susceptible to chiropractic manipulation. In his view, it would be totally inappropriate to give spinal manipulations to someone with hypermobility.

[Independent chiropractor] further testified that chronic pain syndrome is a biopsychosocial disease unto itself; the injured tissue or skeletal system no longer serves as the underlying, noxious cause of the pain. It can be precipitated by anyone of numerous events such as, for example, trauma or emotional upheaval. Chronic pain, on the other hand, is pain resulting from injury that continues much longer than should be expected. Chronic pain syndrome usually involves psychological factors; it rarely causes 'impairment' but it can cause 'handicap'. [Independent chiropractor] differentiated between the two by describing impairment as loss of anatomical function of an area due to a physical cause, while handicap is a loss of function, whether temporary or permanent, that does not have a physical origin.

[Independent chiropractor] further testified that chronic pain syndrome can only involve a chiropractor as one member of a multi-disciplinary team, with goals that are reasonable, achievable and patient-generated, having as their primary objective making the patient independent and active, not reliant upon passive care. It is vital, said [independent chiropractor], to avoid passive interventions which foster dependence by emphasizing to the patient that he/she is disabled.

He had classified [the Appellant] as a Grade 2 Whiplash Associated Disorder, with some limitation of her range of motion, neck pain but no neurological deficits. According to the leading text, about 33 treatments spread over some 29 weeks would be the anticipated norm for chiropractic adjustments, depending upon the presence or absence of modifying factors such as tortional injury, unpreparedness of the patient at time of impact, inter-articular adhesions, the size and gender of the patient and, more obviously, the mechanics of the impact generally. Modifying factors, if present in sufficient number or severity, could increase chiropractic

treatments by a factor of up to two times. In [the Appellant's] case, [independent chiropractor] was emphatic in his opinion that further chiropractic treatments directed towards the reduction of pain would not help [the Appellant] at all. "Pain" is sensory or emotional response to actual or perceived tissue damage.

"Fixation" is hypomobility, said [independent chiropractor]. There was nothing in [Appellant's chiropractor #2's] report to support a diagnosis of nerve root compression. [The Appellant's] problem was primarily a psychological one, to be found currently in the fact that, as she starts to get better - a fact that removes the 'crutch' of her pain upon which she has become dependent - she will automatically pull away from, or reject, helpful treatments aimed at improving her functional capacity. [Independent chiropractor] was concerned that [the Appellant] would gravitate to practitioners who would tell what she wanted to hear rather than what she needed to hear.

[MPIC's chiropractor]

[MPIC's chiropractor] testified that, upon reviewing all of the medical and chiropractic evidence on [the Appellant's] file and, in particular, the more recent reports from [Appellant's chiropractor #2], it was his view that [Appellant's chiropractor #2's] report in February 1998 showed no real improvement over that which was reflected in his report of January 1997.

[MPIC's chiropractor] expressed particular concern over a report from [Appellant's chiropractor #2] that [the Appellant] had shown a brachioradialis reflex of plus 4 which, said [MPIC's chiropractor], in his view was always pathological. Plus 2 was normal; 0 reflected an absent reflex, but plus 4 is most frequently seen in primary neurological diseases or spinal cord trauma.

"If a patient presented, right after a motor vehicle accident, with a plus 4 reflex, I would put him in a collar and send him off in an ambulance to hospital; if such a patient presented with a plus 4 several months after an accident, I would send him post-haste to see his physician and I would not think of treating him."

[MPIC's chiropractor] went on to say that plus 3 strength of deep neck musculature is about equal to that of an infant who is just starting to get some control of his head and neck; he can lift his head but almost anything will defeat that movement. [Appellant's chiropractor #2's] assessment of [the Appellant] had shown a great number of radiculopathies, producing serious muscular deficits, of a number and degree that he, [MPIC's chiropractor], had never seen before. If he had seen a patient with a plus 4 Grade reflex he would have been highly alarmed. However, [MPIC's chiropractor] testified, having reviewed [the Appellant's] file in its entirety and finding that none of the other experts who had examined her had noted the same phenomenon, he had been less inclined to feel great concern.

[MPIC's chiropractor] expressed the opinion that [Appellant's chiropractor #2's] reported series of treatments was not in accordance with the guidelines for chiropractic practice in Canada. Those guidelines indicate that, if a patient has reached maximum therapeutic benefit, he/she should be either totally discharged or referred out to another discipline. He felt it clear that [the Appellant] had, indeed, reached maximum therapeutic benefit from her chiropractic adjustments by the time MPIC had quit paying for her chiropractic treatments, if not sooner.

Quoting from one of the leading writers on the subject, Dr. Arthur Croft, [MPIC's chiropractor] spoke of the need for a transition from passive to active care, in more complicated cases, over the course of six to twelve months, with the last half of that time emphasizing active care. Failure of

a patient to respond to treatment is not a reason to continue the same treatment - quite the contrary - said [MPIC's chiropractor]. Hypermobilization can result from prolonged care at a high frequency. An even greater risk of dependency then arises, in addition to the physical danger. If hypermobility exists, spinal manipulation may well aggravate that condition, and fibromyalgic patients as a group tend to present with hypermobility.

[MPIC's chiropractor] further testified that "Almost everyone has subluxations. To my knowledge, it is not possible to distinguish between trauma-induced subluxation and any other kind, unless there is a fracture, in which latter case we would not be giving spinal adjustments".

[MPIC's chiropractor] further testified that:

> We are now well past the acute physical rehabilitation stage for [the Appellant]. What is needed is an intensive program with a rehabilitation psychologist to help [the Appellant] break through the pain barrier, followed by physiotherapy or other goal-oriented (as opposed to pain-governed) physical rehabilitation. I compare this to someone with a broken leg, whose most excruciating pain is often at the point when they take off the cast and start to walk: if the program is halted because of the pain, that patient is more likely to sustain permanent damage.

[MPIC's chiropractor] added that, even had [the Appellant's] second accident been serious, the time that had elapsed between that accident and the date of his report was more than enough for the healing process to have taken place or, at least, enough to show marked progress from chiropractic treatments; no such progress was apparent to him.

The Commission notes that [Appellant's chiropractor #2] appears to have agreed with the view expressed by [independent chiropractor] and [MPIC's chiropractor] that, despite being treated at a frequency of at least three times per week since her second motor vehicle accident in June of

1996, [Appellant's chiropractor #2's] report of February 12th, 1998 describes [the Appellant] as being in worse condition than she had been in his first report.

The Law

Since [the Appellant] has already been paid the lump sum of $6,300.00 for each of the three terms that she was unable, by reason of her accident, to complete at the post-secondary level - a total of $18,900.00 - pursuant to Section 91(2) of the MPIC Act, the relevant portions of the Act and Regulations that remain applicable to this appeal consist of certain definitions under Section 70(1), Sections 89, 90, 91(3), 92, 107, 110, 131, 136(1) and 138 of the Act, together with Section 5 Manitoba Regulation No. 40/94. Copies of each of the foregoing sections are attached to and intended to form part of these reasons.

Findings of Fact

We find that:

1. there is little, if any, evidence of [the Appellant's] inability, because of her accidents, to care for herself or to perform the essential activities of everyday life without assistance - not, at least, beyond August of 1996, to which point she had been paid personal assistance benefits in the aggregate sum of $3,600.00 plus statutory interest;
2. [The Appellant] had, by February 12th, 1997 (two years after her first motor vehicle accident), if not sooner, attained maximum therapeutic benefit from her chiropractic treatments. We base that finding upon the sum of all of the other medical and chiropractic evidence available to us;

3. in her first motor vehicle accident of February 12th, 1994, [the Appellant] had sustained mild injuries to her neck and to the cervical and thoracic regions of her spine, resulting in some limitations of range of motion but no neurological deficits. She was properly diagnosed as having a Grade 2 Whiplash Associated Disorder in the context of those injuries. She had, in addition, either in that first accident or from the cumulative effect of both accidents, sustained some musculoligamentous injuries to her right shoulder, her right hand and, probably, her right arm;

4. [The Appellant] would, in the ordinary course, have been restored to as close to pre-MVA condition as is possible within approximately twelve months following her second motor vehicle accident, at the latest. However, [the Appellant's] injuries did not follow the ordinary course: the healing process was seriously impaired by psychological barriers that have been variously diagnosed (by [Appellant's psychiatrist] and, although with less certainty, by [Appellant's psychologist] and [MPIC's psychologist]) as Borderline Personality Disorder, and (by [Appellant's psychologist], [Appellant's pain management specialist], [Appellant's doctor #5], and [MPIC's doctor #2] and [text deleted], physiotherapist) as displaying Chronic Pain Behaviour Syndrome or Abnormal Illness Behaviour, by [Appellant's doctor #3] as having chronic myofascial pain of shoulder girdle and neck, and by [Appellant's doctor #3], [Appellant's internal medicine specialist] and [Appellant's rheumatologist] as having fibromyalgia syndrome or chronic fatigue syndrome, or both.

   It is, perhaps, not too surprising that [the Appellant], who almost undoubtedly had at least some of the underlying traits of Borderline Personality Disorder prior to her first accident, would find increasing frustration, confusion and feelings of anger as she continued to receive different messages and different suggestions for treatment from different caregivers, almost all of them highly regarded specialists in their respective fields.

5. The two, common threads that seem to run through the entire cloth of [the Appellant] symptomatology and clinical assessments are these: firstly, no one seems seriously to have suggested any malingering on her part - to her, her pains and her inner conviction of disability were real; secondly, whatever the labels attached to it, it is clear that there was a paucity of physiological signs, and no neurological deficit of any consequence, enabling [the Appellant's] caregivers to isolate and deal with the source of her symptoms. The Borderline Personality Disorder, of which there is much mention in several medical assessments contained in [the Appellant's] file, probably existed, at least to some degree and below the surface, prior to her first accident. While we are unable to find that either of her accidents caused that disorder (if that is what it is) we do find that either her first accident or the cumulative effect of her two accidents brought to the surface the condition from which she now obviously suffers. This is a young woman who, so far as all the evidence before us can indicate, was coping very well prior to February 12th, 1995. She was, if anything, an over-achiever, both in her studies and in her off-campus activities.

6. While it is undoubtedly true that there is little scientific literature to establish a direct chain of causation between the trauma of a motor vehicle accident and subsequent fibromyalgia syndrome, we cannot completely ignore the temporal relationship between them; where an apparently healthy woman, succeeding in most, if not all of her activities, is the victim of two motor vehicle accidents and, within a comparatively short time thereafter, starts to develop the symptoms described above, we do not think it unreasonable to attribute the one to the other. We have reference to the case of Dickson vs. Canada Life Casualty Insurance Company et al, 32 O.R. (3d) 175 wherein Eberhard J., in circumstances not too dissimilar from those before us now, found that the timing and development of fibromyalgia or chronic pain syndrome supported the finding of a causal link to physical injury, even though fibromyalgia could arise from non-physical causes. Eberhard J. recognized that the

etiology of fibromyalgia was not yet known. However, having found that the plaintiff in that case had no pre-existing medical condition relevant to her then current complaints, that there was no evidence of malingering, and that the plaintiff had full range of movement and physical fitness, he went on to say, in part:

> …..Mechanical fitness cannot be equated with ability to perform a physical function where doing so results in intolerable pain.
> Moreover, on the evidence here, the timing and development of the chronic pain support a finding of causal link to the injury. It followed, without interruption, upon soft tissue injuries that did not resolve as was hoped and expected by medical observers, but persisted and increased after the first few weeks of physical injury. I find there is a clear link between the physical injury and the complications of injury that, in combination, give rise to Ms Dickson's impairment. There is no reason to suppose that the complications would have developed at all but for the originating physical injury. I find that this is not a case where the impairment has as its source cognitive, emotional or psychological genesis….On a balance of probabilities….physical injury is at least one of the continuing causes of impairment.

It may well be the case that [the Appellant] had a Borderline Personality Disorder or some other, similar, psychological problem that predated her first accident but, in our respectful view, even if that did exist it would not preclude the validity of her present claim. The fragility of her psyche (if that was, in fact, the case) would merely be akin to a 'thin skull' or, perhaps, a 'crumbling skull', and in either event the insurer must take the victim as it finds her.

The Issues

The issues before us, and the conclusions that we have reached with respect to each of them, are these:

1. **Is [the Appellant] entitled to the continuance, or recommencement, of chiropractic treatments?**

As we have noted earlier, since [the Appellant] had received in excess of 200 spinal adjustments from [Appellant's chiropractor #2] by February 26th, 1997, when MPIC discontinued further payments for chiropractic services, with no demonstrable, permanent improvement, we have no hesitation in concluding that MPIC was justified in that decision. Our conclusion in that context is supported by the fact that, by the time [the Appellant's] appeal was heard by this Commission, the number of chiropractic treatments she had received appeared to have risen by something in excess of a further 150 but, again, with no demonstrable improvement. The clinical guidelines for chiropractic practice in Canada, published by the chiropractic profession itself, together with much of the available literature, such as Dr. Lawrence S. Nordhoff's text entitled "Motor Vehicle Collision Injuries - Mechanisms, Diagnosis and Management" (1996 edition), all tell us that [the Appellant] had certainly reached, and exceeded, maximum therapeutic benefit. We express concern that continued spinal adjustments are likely to create excessive hypermobility and, in consequence, produce more harm than good. We appreciate that [Appellant's chiropractor #2] has continued to treat [the Appellant] and, from what they both tell us, without receiving any professional fees for most, if not all, of his treatments since the 26th of February 1997. We do not doubt [Appellant's chiropractor #2's] sincerity, but the question that we are required to decide is whether those treatments were medically required, within the meaning of Section 5(a) of Manitoba Regulation 40/94. Regrettably, we are not persuaded that those treatments were medically required, and this aspect of [the Appellant's] appeal must, therefore, be dismissed.

2. **Is [the Appellant] entitled to reinstatement of income replacement indemnity and, if so, between what dates?**

This is the most difficult issue facing us in this appeal. We have the opinion of [Appellant's psychologist] that, by as early as September 12th, 1996,

> The usefulness of psychological input may well have been reached. She has been given the tools, she now needs to implement them.

At first reading, [Appellant's psychologist's] comment quoted above might well be interpreted (as it was, in fact, interpreted by MPIC) to mean that [the Appellant] required no further psychological counseling and merely had to decide, of her own volition, to recommence the physical components of her therapy in order to achieve functional restoration. In fact, however, [Appellant's psychologist's] comment has to be read in context. She had been asked what had to be achieved in order to fit [the Appellant] for re-entry into rehabilitation and the workforce, and what time line for treatment she had established. Her response was that [the Appellant] needed a decrease in psychological symptomatology and increase in wellness behaviours, attitudes and abilities. She felt that a team evaluation of the situation was needed and then added the comment quoted above which, seen in that context, was more speculative than determinative. In other words, her comment should, in our view, be paraphrased to read "Perhaps I have gone as far as I can go with [the Appellant] - who knows? I can't tell you how long her recovery will take; let's get together and talk about it."

In any event, we have concluded on a strong balance of probabilities that [the Appellant's] first motor vehicle accident resulted in some comparatively minor musculoligamentous injuries, aggravated to a minor extent by her second accident, and that what should have been a reasonably short period of recuperation - no more than a year, at most - was prolonged to the remarkable degree that we have described above by reason of psychological barriers, present to a manageable extent prior to February 12th, 1995 but set alight and magnified not only by her accident but, ironically enough, by the multiplicity of, the pressures and perceived stress, and even the attention from, the caregivers who were, with the utmost of good faith and to the best of their skills, trying to help her.

We are also forced to conclude that this unhappy chain of events would not have taken place had it not been for her two motor vehicle accidents. Her condition obtains up to the present time, and appears to have done so without significant interruption. We conclude, therefore, that her entitlement to income replacement indemnity should be reinstated from February 26th, 1997 and should continue until the completion of the program referred to in the following portion of these reasons. Simply put, while it may well be true to say that there has been no physical reason why she could not have returned either to her studies at the [text deleted] or to the course for which she registered at [text deleted], physical capability is of little use unless accompanied by the psychological ability and that, it seems clear, was the missing factor.

3. **Is [the Appellant] entitled to further forms of therapy at the expense of MPIC?**

[MPIC's doctor #2], [independent chiropractor] and [MPIC's chiropractor] - all consultants for MPIC - as well as [Appellant's psychologist] and [Appellant's doctor #6], have all said, each in his or her own way, that what is needed for [the Appellant] is, first and foremost, some intensive counseling by a psychologist with particular skills in the management of pain. Once [the Appellant's] psychological counselor is of the view that she is ready to resume a modicum of physical rehabilitation, then she should undergo a functional capacity evaluation, to be followed by a carefully planned program of functional restoration under the guidance of a competent physiatrist and, to quote [MPIC's doctor #2], "a very caring and supportive physiotherapist". [MPIC's doctor #2] noted that physiotherapy had already been tried and found wanting, so that there was little purpose to be served in returning to the physiotherapy component until [the Appellant] had achieved a reasonable measure of pain management. While one or two of [the Appellant's] caregivers appeared ready to give up, and to say that nothing useful could be done for her, this Commission concurs with the majority of those whose opinions we have read or heard, in

believing that a carefully planned, time-limited, multidisciplinary approach along the foregoing lines can and should, with [the Appellant's] active, sincere and enthusiastic cooperation, restore her to a point at which she can function well in society and rejoin the workforce in a capacity suited to her abilities.

Since it is also clear that [the Appellant's] shoulder and neck problems were almost certainly caused by one or both of her motor vehicle accidents, and since, from her own testimony, it is those very portions of her body that seem to be preventing her functioning effectively and from resuming her work habits, we suggest that, as part of any reassessment or evaluation prior to commencing any physical rehabilitation, it might be fruitful to refer [the Appellant] for an assessment by yet one more shoulder specialist, if only to give her the reassurance that her shoulder is anatomically intact (or as the case may be) and that she can get on with her life. This suggestion is not intended to form part of this Commission's formal Order. Its practicality and usefulness are matters we prefer to leave to the physiatrist selected as part of [the Appellant's] therapy team.

Needless to say, none of the foregoing is likely to be of any value to [the Appellant] without her cooperative participation: without it, MPIC will have done all that can reasonably be expected of it in fulfilling its obligations under Section 138 of the MPIC Act; with it, we are of the view that [the Appellant] can be reintegrated into the workforce. Although she will probably continue to experience discomfort or even pain from time to time thereafter, by taking responsibility for her own life, as she must now start to do, she will be able to work through that discomfort, live with it and overcome it.

Costs

Counsel for [the Appellant] argues strenuously that this Commission should award [the Appellant] her legal costs of this appeal. It is moot whether this Commission has the power to award costs - for example, it is at least arguable that the language of Section 177(3) of the MPIC Act is capable of that interpretation. However, whether we have that power or not, this Commission decided from the outset that it would never attempt to do so except in a case of extreme oppression, bad faith or other serious misconduct on the part of the insurer, or conduct encroaching upon the field of fraud on the part of an insured. The reason underlying that philosophy on our part is simply stated: the object of the statute is to make the appellate procedure as relatively simple, speedy and inexpensive as possible; if we were to award costs to a successful appellant, justice would require us to award costs against an unsuccessful appellant which, patently, would effectively discourage the overwhelming majority of victims from seeking the redress to which they feel entitled. Hence, costs will not be awarded.

It is clear that the difficulty in successfully treating patients having characteristics of chronic pain syndrome / symptom magnification / abnormal illness disorder / post-traumatic stress disorder/ borderline personality disorder increases with every month that elapses between the event that triggers it and the commencement of counseling. We are convinced that, in such cases, the first three months post-MVA are most crucial. We recommend to MPIC that it establish a form of triage or screening system whereby a victim who appears to be developing any of the foregoing characteristics can be directed into a pain management program of psychological counseling at the earliest possible date. MPIC's personal injury adjusting and case management personnel may need a series of seminars, conducted by specialists in the field, to help them recognize the early signs and to teach them how to handle such cases, if those measures are not already in place.

Dated at Winnipeg this 8th day of March, 1999.

J. F. REEH TAYLOR, Q.C.

LILA GOODSPEED

F. LES COX