Automobile Injury Compensation Appeal Commission

IN THE MATTER OF an appeal by [the Appellant]
AICAC File No.: AC-98-40

PANEL:	**Mr. J. F. Reeh Taylor, Q.C., Chairman** **Mr. Charles T. Birt, Q.C.** **Mrs. Lila Goodspeed**
APPEARANCES:	**Manitoba Public Insurance Corporation ('MPIC') represented by Mr. Keith Addison;** **the Appellant, [text deleted], was represented by [Appellant's representative]**
HEARING DATE:	**January 5th, 1999**
ISSUE(S):	**i) Whether termination of benefits for non-compliance justified;** **ii) causation - whether appellant's condition caused by MVAs.**
RELEVANT SECTIONS:	**Sections 83(1), 84(1) and 160 of the MPIC Act.**

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

[The Appellant], a [text deleted] year old sewing machine operator at the date of her first motor vehicle accident on August 12th, 1995, was initially seen and treated by her family physician, [text deleted] who, in turn, referred her to the [text deleted] Physiotherapy Clinic. She attended there from September 15th, 1995 to June 7th, 1996. She had, in the meantime, been referred by Manitoba Public Insurance Corporation ('MPIC') for vocational/medical case management to

[vocational rehab consulting company], whose consultant assigned to her case was [Appellant's vocational rehab consultant].

[The Appellant's] response to physiotherapy had not been particularly good although, it appears, her response to going without therapy had been even worse.

She was referred by [Appellant's vocational rehab consultant] to [text deleted], an orthopedic specialist with the [text deleted] Clinic, who saw her on January 25th, 1996. [Appellant's orthopedic specialist] felt that [the Appellant] had a soft tissue injury following her motor vehicle accident ('MVA') and felt that only time and further physiotherapy would help her. He said she would likely go through three phases: pain, stiffness and then gradual recovery. He anticipated she would be able to return to her previous employment eventually. He noted that, although she had a poor response to physiotherapy, it was still relatively early in the game and he encouraged [the Appellant] to continue range of motion exercises as her pain tolerance allowed.

At a team meeting on June 6th, 1996, apparently organized by [Appellant's vocational rehab consultant] and attended by [Appellant's doctor #1], [Appellant's physiotherapist #1], [text deleted] (MPIC's adjuster) and [the Appellant], there appears to have been general agreement amongst her caregivers that she should start a six week program at [rehab clinic] aimed at functional restoration and eventual work hardening, with a full psychological assessment. [Appellant's doctor #1] therefore completed the appropriate form referring [the Appellant] to [rehab clinic] for an assessment and to set up a multi-disciplinary approach to treatment focusing on function and the psychological barriers apparently impeding [the Appellant's] return to work. She was to receive occupational therapy, physiotherapy and psychological counselling,

concurrently. While the foregoing suggests that there was total agreement between all parties at that team meeting, it must be added that [the Appellant], while paying lip service to a desire to become well again and to return to work, appears to have resisted strongly almost all efforts made by her caregivers to that end - even when she was attending the various aspects of her restorative programs. At the meeting on June 6th, 1996, in fact, she is reported to have stated that she would not return to work in any capacity until her health had returned to normal, flatly refusing to participate in any gradual return to work program. Despite that declaration of intent, [the Appellant] did, in fact, start participating in the program, although with a marked lack of enthusiasm. Both [Appellant's doctor #1] and [Appellant's physiotherapist #1] agreed that there was no identifiable, objective reason why she should not be able to increase her functional abilities. The functional restoration program at [rehab clinic] commenced on August 7th, 1996 and involved, initially, only physiotherapy and psychology components since it was determined that [the Appellant] was not yet ready for occupational therapy.

By September 3rd, 1996, [the Appellant], who had been attending the physiotherapy program three times per week, with psychological counselling once a week, said that she had noticed no improvement physically and could not understand how psychology might be of benefit to her since "I am not crazy and I know what I am doing".

By October 24th, [Appellant's vocational rehab consultant] and the team at [rehab clinic] had developed a new schedule for [the Appellant] to follow, this time including occupational therapy, starting with one hour per day in the first week and intended to work up to eight hours a day by the end of the twelfth week, subject to review at the end of the sixth week. [Appellant's doctor #1] gave his written concurrence to that program on November 7th.

[Appellant's doctor #1] then referred [the Appellant] to [text deleted], a specialist in rheumatic diseases, who assessed her as having adhesive capsulitis of the right shoulder (which had apparently improved materially with physiotherapy), myofascial pain syndrome involving the right trapezius, and fibromyalgia. [Appellant's rheumatologist] also advised [the Appellant] that she should continue on physiotherapy and that he would also refer her to the Department of Rehabilitation Medicine for consideration of the needling of trigger points. He told [the Appellant] that he did not think she had `a disorder that would leave her crippled or deformed in any way but that her recovery might well be slow.

For the next short while, [the Appellant] appears to have been in regular attendance at [rehab clinic]. Both her physiotherapist and psychologist noted some improvements and agreed to the coordination of an occupational therapy component. That was agreed upon by all parties and the occupational therapy program started on November 18th of 1996, albeit very slowly indeed.

Then, about mid-December, [the Appellant] starts a series of absences. She fails to show up on December 11th, 12th, 18th and 19th; does not see [Appellant's doctor #1] after November 25th, 1996 and does not attend to see [text deleted], the psychologist working with the [rehab clinic] program, after about mid-December.

On December 20th, 1996, [Appellant's vocational rehab consultant], the vocational rehabilitation consultant with [vocational rehab consulting company], received a telephone call from [Appellant's doctor #2] who apparently said that, although he was not [the Appellant's] regular physician, she had consulted him and, since he understood she had been diagnosed with

fibromyalgia, he had advised her not to participate in the program at [rehab clinic]. Although [Appellant's vocational rehab consultant] suggested to [Appellant's doctor #2] that fibromyalgia, even if present, would not normally preclude [the Appellant] from participating in a work hardening program, [Appellant's doctor #2] insisted that [the Appellant] would be unfit to attend such a program from December 18th, 1996 to January 3rd, 1997. [Appellant's doctor #2] presented no objective reasons for this advice; he appears merely to have been relying upon [the Appellant's] own complaints of pain. [Appellant's doctor #2] provided [the Appellant] with two, subsequent memoranda, to the effect that she was "unfit to attend hardening program" from January 3rd, 1997 to January 10th, 1998 and, on January 14th, for two weeks thereafter. Again, no supporting, objective signs nor other reasons were advanced by [Appellant's doctor #2] for this advice.

Meanwhile, [the Appellant] appears not only to have quit attending her occupational therapy sessions for functional restoration, but she also quit attending upon [Appellant's psychologist] and her physiotherapy sessions.

On January 23rd, 1997, in response to some direct inquiries from [Appellant's vocational rehab consultant], [the Appellant's] original physician, [text deleted], expressed the view she should continue to participate in the multi-disciplinary program at [rehab clinic] and that, although she had been diagnosed with a hyperthyroid condition, that was unrelated to her motor vehicle accident and should not preclude her continued participation in her functional restoration program.

Due to [the Appellant's] total discontinuance of her functional restoration program, and MPIC's apparent inability to obtain any objective reasons from either [the Appellant] or [Appellant's doctor #2], the Corporation told [the Appellant] that her benefits would be suspended unless she were willing to attend at [rehab clinic] for a reassessment. She nonetheless refused to attend for that reassessment unless and until advised to do so by [Appellant's doctor #2]. [The Appellant] indicated, incidentally, that she had stopped seeing [Appellant's doctor #1] and had started seeing [Appellant's doctor #2] because she was not able to get an appointment with [Appellant's doctor #1]; at the same time, she acknowledged that she had not contacted [Appellant's doctor #1's] office nor made any attempt to schedule such an appointment. Although any patient has, of course, a perfect right to switch from one caregiver to another, we were left with the strong impression that [the Appellant] made that particular change primarily because [Appellant's doctor #1] supported her continuance at the functional restoration program while [Appellant's doctor #2] was more compliant with her wish to be relieved of the effort and the discomfort entailed in that program.

On her way to a meeting with [Appellant's vocational rehab consultant] on January 27th, 1997, [the Appellant] was involved in a second motor vehicle accident when the stationary vehicle in which she was a passenger was apparently rear-ended. She mentioned that accident at the meeting in question although she gave no details of it nor did she advise [Appellant's vocational rehab consultant] that she had sustained any injuries.

As a result of that January 27th, 1997 meeting, when [the Appellant] confirmed that she would not attend at [rehab clinic] even for the purposes of a further assessment, let alone for the continuance of her functional restoration program, MPIC wrote to her on February 27th, 1997

and notified her that her benefits for any injuries sustained in her accident of August 12th, 1995 were being terminated.

(In the interim, [the Appellant] had been examined by [text deleted], physiatrist, whose report which, ironically, recommends minimal physical therapy and greatly increased psychological and, perhaps, psychiatric intervention, is discussed later in these Reasons.)

Meanwhile, on February 11th, 1997 the Corporation opened a new claim file for [the Appellant] with respect to her accident of January 27th, 1997. An appointment was set up for her to attend at MPIC on February 27th, when she and her husband met with her case manager, [text deleted]. At that meeting, [the Appellant] claimed that previous injuries to her neck and shoulder area had been aggravated in her January 27th accident.

In a report dated February 28th, 1997, [Appellant's doctor #2] told MPIC that [the Appellant] had not recovered fully from the injuries sustained in her first accident by the time of the second one. He diagnosed post-traumatic headaches, strain to neck, mid back and lower back, contusions to both knees and 'post-traumatic nervous stress'. His report also diagnosed a Grade 2 Whiplash Associated Disorder and advised the insurer that the Appellant was unable to return to work, being unfit to do any lifting, bending or twisting, a condition that he felt would prevail until March 31st of 1997. He referred [the Appellant] to physiotherapy.

[The Appellant's] Case Manager at MPIC then arranged an appointment for her to re-attend at [rehab clinic] for the purpose of a physical reassessment, for which she attended on March 11th, 1997. That assessment showed decreased cervical and lumbar ranges of motion, decreased

shoulder range of motion (greater in the right than the left side), tightness of the flexor and quadriceps muscles of the right hip, an asymmetric shoulder girdle, a tenderness on the long head of the right biceps tendon, trigger points, particularly in the upper right trapezius and right wrist extensor muscles, a stiff vertebral column and general deconditioning due to inactivity. The report from [rehab clinic] noted that the foregoing physical findings were essentially the same as had existed just prior to [the Appellant's] accident in January of 1997. [Rehab clinic's] physiotherapist also noted that all of those same physical problems were being addressed in the functional restoration program which [the Appellant] was attending up to December of 1996. [Rehab clinic's] recommendation was that a program to improve range of motion and general physical conditioning, akin to the program that [the Appellant] had started in November and December of 1996, would be beneficial. [Rehab's] physiotherapist, [text deleted], emphasized that this was a functional restoration program, not a work hardening program as had been suggested in some correspondence. [Appellant's physiotherapist #2] also emphasized the vital importance of continuing the psychology sessions in conjunction with the physical ones. [Appellant's physiotherapist #2] recommended that [the Appellant] attend two to three sessions of clinical psychology prior to commencing her physiotherapy and occupational therapy components. It is of major importance to note that, on March 25th, 1997, [Appellant's doctor #2] wrote to [Appellant's psychologist], to say "I am referring [the Appellant] for assessment and treatment by [Appellant's psychologist] and then to OT and PT at [rehab clicnic] ".

[The Appellant] had been referred by [Appellant's rheumatologist] for a consultation with [Appellant's physiatrist], who met with her on February 4th, 1997. [Appellant's physiatrist] is a specialist in physical medicine and rehabilitation. The essence of [Appellant's physiatrist's] report is that, while there were minimal physical barriers preventing a return by [the Appellant]

to her previous occupation and reasonably full functional restoration, there were major psychological factors which could only be addressed by psychiatric and/or psychologic intervention. [Appellant's physiatrist] suggested that any physiotherapy and functional restoration program be put into a maintenance phase, and that she remain active although with the program not being oriented towards maximizing potential until the psychological factors had been overcome or, at least, brought under reasonable control. He certainly felt that she should remain involved with some sort of physical activities on an on-going basis, to avoid further loss of fitness and strength. [Appellant's physiatrist], in a subsequent letter to MPIC, also noted that [the Appellant] was suffering from hypothyroidism which, he said, might be a complicating and perpetuating factor with regards to her chronic pain experience. She also had low levels of folic acid, another propagating factor for muscular pain syndromes. Since all of [the Appellant's] caregivers appeared at that point to be unanimous in their view that she needed some psychological counselling to be followed by a multi-disciplinary approach to her functional restoration, arrangements were made by MPIC for her to see [Appellant's psychologist] on March 31st and on April 4th of 1997. She recommenced physiotherapy on April 24th at a frequency of three times in that first week, moving to a daily physiotherapy session in the week of April 21st. She also returned to occupational therapy on April 18th.

As noted above, on March 31st, 1997 [the Appellant] was seen by [Appellant's psychologist] for reassessment. She had not returned to her former employment since August 12th, 1995, and had been receiving Income Replacement Indemnity from the seventh day following her second accident. [Appellant's psychologist], after describing [the Appellant] as being extremely pain-focused and at a severe level of anxiety and depression, recommended that [the Appellant] required extensive psychological treatment in addition to her involvement with [rehab clinic]. (It

should be recalled that [Appellant's physiatrist] had prescribed only a maintenance level of activity at [rehab clinic] and we must presume that this is also what [Appellant's psychologist] had in mind. She needed to remain active by not only attending [rehab clinic] but also continuing with her physical activities at home and shifting her focus from being totally dependent on the medical staff to taking responsibility and increasing her own general physical functioning. [Appellant's psychologist] did not believe that the Appellant was ready to discuss any vocational planning, nor even exploration of different vocational options, since she currently perceived herself as totally disabled and was completely focused on her pain. Vocational exploration could be done in the future, said [Appellant's psychologist], depending upon her progress in the physical/psychological therapy.

On May 5th, 1997, the occupational therapist at [rehab clinic] advised MPIC that the Appellant was able to start her work simulation program on May 5th, starting at two hours per day and increasing by one hour per day in each succeeding week, with a view to having her resume her regular, full-time duties as a sewing machine operator by the end of June. We express some surprise at this assessment, in light of the comments offered by [Appellant's physiatrist] and [Appellant's psychologist] and the absence of anything further from either of them to indicate that the major psychological barriers to which they both referred had yet been surmounted. It is therefore not too surprising that [the Appellant] missed one day in each of the following weeks and, during the times that she did attend for her occupational therapy sessions, she is reported as having put in minimal effort.

On June 12th, 1997, on referral from [Appellant's doctor #2], [the Appellant] attended at the [text deleted] Clinic at the [hospital] where she was seen by [Appellant's doctor #3]. He felt that her

symptomatology was due to a classical fibromyalgia which started as a whiplash injury following her first motor vehicle accident, aggravated by the second one. He felt that trigger point injections, massage, stretching exercises, heat, anti-depressants and analgesics might help with time, but that time was the cure.

Continued absences by [the Appellant] from both physiotherapy and occupational therapy portions of her functional restoration program caused MPIC to write to her on June 17th, 1997, urging her to put forth maximum effort and to attend her program as required, since failure to do so would put her benefits in jeopardy. She was also reminded that she had yet to respond to a message left for her on June 5th.

June 17th, 1997 was the last day upon which [the Appellant] attended at [rehab clinic] and, by July 21st, [rehab clinic] had not heard either from [the Appellant] nor from her physician, [Appellant's doctor #2], as to the reason for that stoppage. The joint report from the occupational therapist and physiotherapist at [rehab clinic], following her discharge from their program, was that [the Appellant's] work capabilities matched the critical demands of the goal to return her to work as a sewing machine operator. However, her work tolerance was only demonstrated to be up to five and a half hours per day, due to the abrupt ending of her program. Her therapists had anticipated that, by the end of eight weeks of functional restoration, [the Appellant] would have attained a tolerance of six and a half hours per day at which point she could have returned to her pre-accident employment, full-time.

On July 22nd, 1997 [Appellant's doctor #2] wrote a letter, addressed "To whom it may concern", expressing the view that [the Appellant] had not recovered from the injuries she had sustained in

her two MVAs. She complained of pain and stiffness in the neck, shoulders and whole back; she complained of burning pain in both elbows and knees, a painful chest, occipital headaches on the right side, decreased memory, lack of concentration, an inability to do things quickly, depression and fatigue. [Appellant's doctor #2] reported that the Appellant was suffering from "fibromyalgia, post- head-injury syndrome and post-traumatic depression". He felt that she was unfit to sit longer than half an hour, unfit to do any bending, lifting more than ten pounds or work in a bended position. [Appellant's doctor #2] opined that the fibromyalgia and post-head-injury syndrome were permanent and that [the Appellant] would never be fit to return to her former work as a sewing machine operator. [Appellant's doctor #2], whose recommendations to MPIC and whose advice to his patient seem to have been self-contradictory at times, does not explain, nor give any objective, clinical signs or reasons for the 'post-head-trauma' diagnosis; fibromyagia syndrome - a label attached to a bundle of self-reported symptoms rather than a scientific diagnosis, - may in some patients be permanent but is seldom permanently disabling. His pessimistic prognosis was, in our respectful view, more likely to reaffirm [the Appellant's] sense of incurable disability than to help her, if not towards total recovery, at least towards an ability to cope and live with her problems.

On August 27th, 1997 [the Appellant's] Case Manager, [text deleted], wrote to [the Appellant] at some length, spelling out the history of MPIC's attempts to engage her in a functional restoration program and identifying her failure to attend that program as scheduled, her failure to put out maximum effort when she was attending, her failure to notify one of her therapists directly if she intended or expected to be absent from the program, and her abrupt discontinuance of her eight week program after six weeks of sporadic attendance. [Appellant's case manager] therefore advised the Appellant that her benefits were being terminated retroactively, as of June 30th, 1997,

pursuant to the provisions of subsections (d), (e) and (g) of Section 160 of the MPIC Act. (A copy of that section is annexed to these reasons).

On September 23rd, 1997 [the Appellant] filed an application for an internal review of the decision to discontinue her benefits. The Internal Review Officer conducted that review on December 18th, 1997, when both [Appellant's husband] and [the Appellant] attended at his office. As the Acting Review Officer, [text deleted], stated,

> ….There is no suggestion that you have fully recovered from your injuries or that you are presently ready to resume your pre-accident employment. The various reports on the file support your need for further rehabilitation.
>
> You confirmed that the chronology of events set out in the letter from [Appellant's case manager] is accurate. You also confirm that your new physician, [Appellant's doctor #2], is the only health care practitioner who has told you not to participate in the comprehensive rehabilitation program designed by various professionals to (hopefully) restore your functional ability to return to work. ……(*we note that this was not entirely accurate, since others had also suggested at least a lessening or moderating of the physical aspects of her therapy)*… You were warned on numerous occasions, in person, on the telephone and in writing, that your benefits might be terminated if your failure to cooperate continued. You remained non-compliant, however, and left [Appellant's case manager] with no other course but to discontinue your benefits.

In his decision of January 5th, 1998 [MPIC's Internal Review Officer] confirmed the decision of [Appellant's case manager] to terminate [the Appellant's] benefits as of June 30th, 1997.

[Appellant's doctor #2] referred [the Appellant] to [Appellant's pain management specialist] at the [text deleted]. [Appellant's pain management specialist] saw her on January 16th, 1998. [Appellant's pain management specialist's] assessment was of depression, accompanied by wide-spread musculoskeletal pain in four quadrants. He prescribed a therapeutic dose of an anti-depressant and said:

> I am referring her [Appellant's anxiety disorder specialist] at the [hospital] [text deleted] Clinic, who has a great deal of experience in treating depression and co-existing pain states. In the meantime, I will be following her up regularly….

[Appellant's pain management specialist] saw [the Appellant] again on or about February 4th, 1998 and his very brief report to [Appellant's doctor #2] of that date (of which, we note, a copy was sent to [Appellant's anxiety disorder specialist]) says that he had seen [the Appellant] several times to increase her dosage of anti-depressant, which she had stopped because of headaches. "I think she needs to be on anti-depressant therapy and have referred her to [Appellant's anxiety disorder specialist]". Curiously, [the Appellant] does not appear ever to have attended upon [Appellant's anxiety disorder specialist] and, so far as we can tell from the records available to us, neither [Appellant's pain management specialist] nor [Appellant's doctor #2] appears to have actually made such a referral or, if one was made, to have followed it up. We are, therefore, simply left to surmise whether this was another occasion when [the Appellant] decided not to attend upon [Appellant's anxiety disorder specialist] because she was "not crazy", or whether [Appellant's pain management specialist] and [Appellant's doctor #2] dropped the ball between them and never actually made the appointment for her. It is certain that [the Appellant], herself, never did make any attempt to contact [Appellant's anxiety disorder specialist], nor did she pursue the matter with [Appellant's pain management specialist]. As a

result, the form of therapy most urgently needed by [the Appellant] was allowed to fall between the cracks.

A letter from [Appellant's doctor #3], addressed to [the Appellant's] counsel on April 27th, 1998, expresses the view that the Appellant had developed a chronic pain syndrome consistent with fibromyalgia. [Appellant's doctor #3] said that he was not sure that work hardening exercise or therapy would benefit her at that juncture since she required softening and stretching of her muscles rather than their contracting. It would take time, said [Appellant's doctor #3], but he was hopeful that she would improve in due course. A further letter from [Appellant's doctor #2] to [the Appellant's] counsel, dated June 22nd, 1998, confirmed his earlier diagnosis of fibromyalgia, post-traumatic depression, whiplash injury to her neck, and a strain to her back and both shoulders. He described her abnormal pain behaviour and recommended gentle stretching exercises without the pushing, pulling or lifting that might precipitate pain in her muscles. He felt that she could benefit from trigger point injections, massage therapy, stretching exercises and anti-depressant.

We are faced, then, with a scene of no little confusion. As counsel for MPIC rightly points out, there was a period following [the Appellant's] first accident when all of the medical and paramedical caregivers of [the Appellant] were unanimous in their view that she should follow the functional restoration program. The fork in the road came about when [Appellant's doctor #2], although armed with all of that information, tells her to quit the program. Following her second accident, she was reintegrated into that program for a while, only to quit again upon [Appellant's doctor #2]'s advice.

It is beyond doubt that [the Appellant] did not follow a rehabilitation program made available by the Corporation and did refuse to follow medical treatment recommended by a medical practitioner and the Corporation. One of the questions before us is whether she did so "without valid reason" and, thus, was in breach of Section 160 of the MPIC Act.

Since the date when MPIC's Internal Review Officer, [text deleted], arrived at his decision of January 5th, 1998, additional information has come to hand reflecting other, complicating factors - more specifically, [the Appellant's] mental and emotional condition as well as her hypothyroidism. It certainly seems now to be the unanimous view of all of her medical caregivers that a general exercise program or a functional restoration program are not now indicated for [the Appellant] (whatever may have been called for in June of 1997) but that the involvement of a skilled clinical psychologist or, perhaps, psychiatrist is a necessary prerequisite to any physical restoration of [the Appellant]: that much seems clear.

THE ISSUES:

The two issues facing this Commission are:

1. the question of causality - that is to say, was her present condition brought about by one or both of her motor vehicle accidents?
2. did she have "valid reason" to quit the functional rehabilitation program on both occasions.

The question of causality is complicated by [the Appellant's] hypothyroidism which, clearly, was not caused by either of the motor vehicle accidents but seems, rather, to have been caused by treatment with radioactive iodine intended to cure an hyperthyroid condition known as Grave's

disease. [Appellant's doctor #4], who was treating her for that condition, and [text deleted], MPIC's medical consultant, both agree that, as [Appellant's doctor #4] puts it, "depressions tend to do badly in the presence of thyroid disorders". In [MPIC's doctor's] view, thyroid disorders can cause psychological changes and diffuse muscle aches, and symptoms similar to those described in [the Appellant's] file can occur with hypothyroidism. Our task is not made easier by the fact that the onset of [the Appellant's] Grave's disease seems to have occurred at about the same time as her first motor vehicle accident, even though not caused by that accident.

CONCLUSIONS:

We have concluded that, on a reasonable balance of probabilities, what has happened here may be summarized this way:

(a) an apparently healthy, hard-working woman but with latent Grave's disease (a form of hyperthyroidism) was involved in a motor vehicle accident, resulting in injuries which, in the normal course, might reasonably have been expected to be fully overcome within, say, six months;

(b) hyperthyroidism, an abnormality of the thyroid gland in which secretion of thyroid hormone is usually increased, is characterized by weight loss and tremulousness, amongst other clinical signs, and may progress to severe weakness. These signs were certainly exhibited by [the Appellant], and the treatment that she received in order to counteract the Grave's disease resulted in hypothyroidism which, in turn, also frequently involves muscle weakness. (See Stedman's Medical Dictionary, 25th edition, pages 746, 755 and 1020.) The report of [Appellant's doctor #4] to [Appellant's doctor #1] of December 18th, 1996 notes that [the Appellant] has lost weight, from 165 down to 137 pounds, that

she has had heat intolerance, insomnia, palpitations and tremor. [Appellant's doctor #4] found an eyelid lag, deltoid and quadricep wasting, marked hyperreflexia, and a depressive affect with extensive upper body myofascial pain. The advent of her thyroid problems and their course of treatment, running concurrently with the efforts of her medical and paramedical caregivers to restore her functional capacity, seem to have prolonged a therapeutic program which, in the ordinary course, would have been completed much sooner;

(c) if one adds to that already troublesome mixture the obvious psychological content, remarked upon by [Appellant's doctor #4], [Appellant's pain management specialist] and [Appellant's doctor #2], it is not surprising to find that [the Appellant's] accident-related injuries were still unresolved. Nothing in the material presented to us indicates with any clarity just when [the Appellant's] psychological problems began, but a careful reading of the early vocational assessment reports do seem to indicate that they surfaced within a matter of weeks following her first motor vehicle accident, although we cannot tell whether that accident either caused or triggered her resultant depression. For example, four days after the accident her adjuster notes that she was 'shaky', 'very, very upset' and 'on the verge of tears'; on September 15th, 1995, [text deleted] Physiotherapy report speaks of her complaints of 'headaches, pressure in her head, ……shaking…..very anxious….';

(d) [The Appellant's] second accident, while not apparently very serious, seems to have pushed her even further into the twin physical and emotional states of chronic pain syndrome and clinical depression Notwithstanding the opinions expressed by all of her caregivers in the early stages, that they believed her to be quite capable of completing her functional restoration program and that, in the absence of objective, clinical signs, the

symptoms of which she complained were not in fact disabling, we conclude that her two motor vehicle accidents were the events that triggered the fibromyalgia syndrome, the myofascial pain, and the reduced motion of the cervical spine and right shoulder with which she was diagnosed. We conclude, therefore, that causality is therefore established. Her psychological problems (whether triggered by the motor vehicle accidents or not) and her thyroid problems have prevented an earlier resolution of her physical problems;

(e) on both occasions when [the Appellant] withdrew from her functional restoration programs, she was doing so on the advice of [Appellant's doctor #2]. Whether that advice was well founded, particularly on the first occasion, is moot: the fact is that [Appellant's doctor #2] had, by that time, become her primary caregiver; she quit the programs each time primarily because he told her to do so and the depression from which she was undoubtedly suffering made her less inclined to question the wisdom of such welcome advice. Neither the depression nor the medical advice are faults that can properly be laid at her door. She was getting mixed messages from her other caregivers: her adjuster and the team at [rehab clinic] were telling her that she must try harder; [Appellant's psychologist], on July 3rd, 1996, describes her as presenting with 'severely dysphoric mood, crying spells and a high level of anxiety …….overwhelmed by the suggested rehabilitation process…….high level of apprehension and feelings of victimization' and recommends against any work-hardening program; [Appellant's vocational rehab consultant] and the [rehab clinic] team are still talking of return-to-work; [Appellant's doctor #2] is telling her to do no such thing. Even as late as November 14th,1997, a memorandum from [text deleted], MPIC's medical consultant to its Claims Services Department, reports that, upon a brief review of the file, it was [MPIC's doctor's] opinion that "There was no information on file which absolutely

precluded the claimant from attending the rehabilitation program. *There is also not sufficient information to conclude the opposite."* (Emphasis added.)

(f) We therefore find that, under the particular circumstances of her case, she was entitled to rely upon the advice of [Appellant's doctor #2], and that she did have "valid reason" to quit those programs.

The decision that follows will, therefore, provide substantial benefits for [the Appellant]. However, we are constrained to add two comments. First, our decision has not been arrived at without some misgivings - a victim must assume some responsibility for his/her own rehabilitation, and it has seemed to us that [the Appellant] has been all too willing to follow the most comfortable advice available to her, with its resultant passivity. We have only been prepared to accept that pattern of conduct by reason of her psychological problem, which appears to have predisposed her to inactivity. Secondly, if she fails without valid reason to follow conscientiously the program that is now to be devised for her, MPIC will be justified in again terminating her benefits; it is imperative that she be willing to make every reasonable effort to help herself and to become increasingly less dependent upon her caregivers.

DECISION:

We find that:

(a) [the Appellant] is entitled to such psychiatric care and treatment, or to such psychological counselling, or both, as may be recommended or prescribed by [Appellant's anxiety disorder specialist] at the [text deleted] Clinic, for which purpose she is to be referred

back to [Appellant's pain management specialist] by MPIC in order to have the appropriate appointment made;

(b) at such time in the course of the foregoing treatment or counselling as [the Appellant's] psychiatric or psychologic caregivers may recommend, she is entitled to be re-admitted to a functional restoration program, to be planned and administered by such institution or agency as MPIC may determine following consultation with [the Appellant's] medical caregivers;

(c) [The Appellant] is entitled to the resumption of her income replacement indemnity from July 1st, 1997 until the completion of the programs referred to in paragraphs (a) and (b) hereof; and

(d) [The Appellant] is entitled to interest on the income replacement indemnity at the rate provided by statute. In this latter context, we suggest (although we are without jurisdiction to embody this in an order) that counsel for the parties might wish to agree that interest should be calculated upon the entire outstanding balance of IRI from a date at mid-point between June 30th, 1997 and the date of payment. In that way, a multiplicity of small computations can be avoided. Failing such an agreement, it will be incumbent upon MPIC to cause each of those separate computations to be made separately.

Dated this 10th day of February, 1999.

J. F. REEH TAYLOR, Q.C.

CHARLES T. BIRT, Q.C.

LILA GOODSPEED