Automobile Injury Compensation Appeal Commission

IN THE MATTER OF an Appeal by [the Appellant]
AICAC File No.: AC-00-73

PANEL:	**Mr. J. F. Reeh Taylor, Q.C., Chairperson** **Ms. Yvonne Tavares** **Mr. F. Leslie Cox**
APPEARANCES:	**The Appellant, [text deleted], appeared on her own behalf; Manitoba Public Insurance Corporation ('MPIC') was represented by Ms. Joan McKelvey.**
HEARING DATE:	**Monday, October 16, 2000**
ISSUE(S):	**(i) Causation – whether damage to rotator cuff caused by MVA;** **(ii) Whether benefits terminated prematurely.**
RELEVANT SECTIONS:	**Sections 81(1)(a), 84(1) and 106 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] is a registered nurse. On her way home from work on the night of April 2, 1997, when the vehicle she was driving was stopped for a red light at an intersection, it was rear-ended. By the end of the following day the injuries that she sustained in that collision were causing her sufficient pain that she consulted her chiropractor, [text deleted], first thing on the morning of April 4th. [Appellant's chiropractor] treated her on a regular basis until May 26, 1997 and, after a hiatus of about two months, recommenced those treatments on July 29th. She had twelve

chiropractic treatments up to and including September 12, 1997, at which point she changed from chiropractic to physiotherapy treatments prescribed by her family physician, [text deleted].

[The Appellant's] injuries were variously described by [Appellant's chiropractor] as including, although not limited to "right scapular pain", "right trapezius (and) periscapular muscle spasm", "cervicothoracic strain and dysfunction", and "myofascial pain syndrome". [Appellant's doctor #1] described "intermittent right shoulder discomfort", "right arm parasthesias" and "tender right trapezius and rhomboid".

Meanwhile, [the Appellant] had returned to work on May 14, 1997, feeling, as she said at the time, "relatively well and able to do my job with minimal pain". However, by the end of July the pain in her upper back, neck and right lower back had apparently reasserted itself to a point that precluded her continuing to work. She had returned to the care of [Appellant's chiropractor], whose treatment plan covering a period of some twelve to sixteen weeks was approved by MPIC. The pain was described at that point as "muscle spasm in her neck which radiated down her right arm". Since her chiropractic treatments did not seem to be helping, [the Appellant] again consulted [Appellant's doctor #1], who referred her to physiotherapy commencing September 27, 1997.

On November 17, 1997 [the Appellant] reported to her adjuster that her right shoulder was still giving her a lot of problems and that [Appellant's doctor #1] had referred her to [text deleted], a specialist in sports medicine, who saw her on November 21st. [Appellant's sports medicine specialist's] report to [Appellant's doctor #1] of November 25th says, in part:

> "As you know, she has developed symptoms involving her neck, upper back and shoulder region following a rear-end collision that took place in April of 1997.

> She described pain mostly involving the right scapular region with referral to the right arm and neck. …….
>
> It is my opinion that [the Appellant] was suffering from myofascial pain involving her neck and right scapular regions. I felt that she should continue with physiotherapy with a more structured program regarding proper reconditioning exercises for the various muscles involved."

Although [Appellant's sports medicine specialist's] report to [Appellant's doctor #1] does not say so, [the Appellant] reported to her adjuster a few days later that [Appellant's sports medicine specialist] had told her she might have torn one of her muscles and was going to have to learn to live with her pain.

On December 2nd, [Appellant's doctor #1] opined that [the Appellant] would be unable to work until January 19th of 1998. She also made arrangements for [the Appellant] to be examined by [Appellant's doctor #2] for cortisone injections to her shoulder, and also, through [Appellant's doctor #2], arranged for a neurological assessment and a CT Scan. [Appellant's doctor #1] subsequently expressed the view it would not be possible for [the Appellant] to return to her job before June or July, after the results of her CT Scan had become known and reassessed by [Appellant's doctor #2].

On February 26, 1998, MPIC's case manager in charge of [the Appellant's] claim, [text deleted], met with [Appellant's sports medicine specialist], in the latter's capacity as medical consultant to MPIC's Claims Services Department. [Appellant's sports medicine specialist] indicated that he had already assessed [the Appellant] at the request of her general practitioner, and he undertook to have his secretary forward, to the case manager, a copy of his report to [Appellant's doctor #1].

A report from [Appellant's doctor #2], bearing date April 20, 1998, diagnosed a grade two whiplash-associated disorder, and a possible radicular component at C7. [Appellant's doctor #2] could find minimal objective impairment, other than what he describes as the Appellant's "mild decreased range of motion". He felt that the Appellant's range of motion was sufficient to accomplish the tasks of a registered nurse, although he was still awaiting the results of a CT Scan of her cervical spine and of a nerve conduction study.

As a result of [Appellant's doctor #2's] report of April 20th, [Appellant's MPIC case manager] advised [the Appellant] on May 1st that her Income Replacement Indemnity (IRI) would cease as of May 4th, 1998.

Arrangements were then made, following discussions involving [Appellant's doctor #2], [Appellant's doctor #1] and [text deleted], physiotherapist to whom [the Appellant] had been referred, for [the Appellant] to commence a graduated return-to-work program. The program was to start on May 11th for three hours per day and adding one hour per day in each of the following weeks until, by the week of June 15th, she would be back to working a full eight-hour day. That program was undertaken and, in addition, [Appellant's physiotherapist] commenced applying acupuncture. On May 28th, [Appellant's physiotherapist] referred [the Appellant] to [Appellant's doctor #3] for continued acupuncture, which was to commence on June 9, 1998. In the interim, MPIC had, in fact, been continuing to pay [the Appellant] IRI during her return-to-work program, since her place of employment still found it necessary to have a regular registered nurse on staff while [the Appellant] worked in a supernumerary capacity.

On June 1st, the Corporation made a 180-day determination under Sections 84 (1) and 106 of the MPIC Act, for which purpose [Appellant's MPIC case manager] determined the Appellant's

employment to be that of a registered nurse. Her income replacement indemnity was adjusted accordingly.

On that same date, [the Appellant] wrote to [Appellant's MPIC case manager], expressing surprise at [Appellant's doctor #2's] report, taking strong issue with that report, detailing the numerous areas in which weakness in the Appellant's arm was made manifest and expressing the view that "there is something more wrong in that shoulder that has not been picked up until now". In the event, [the Appellant] proved to be quite right.

On June 17th, [Appellant's MPIC case manager] spoke with [Appellant's doctor #3] who expressed concern about the possibility of an organic problem and did not want [the Appellant] continuing with her return-to-work plan until the results of a pending bone scan were known. However, since no organic disease appeared from the bone scan and blood analysis that had been performed, [the Appellant] returned to her graduated return-to-work program on June 28th, starting at four hours per day.

On July 2nd, [the Appellant] spoke with [Appellant's MPIC case manager] again. She had seen [Appellant's doctor #2] who, she said, had now changed his opinion and believed that there was something wrong with the Appellant's shoulder. He had ordered a Magnetic Resonance Imaging ('MRI') and [the Appellant] was waiting for an appointment to that end. Since [Appellant's doctor #2] appeared reluctant to comment on whether she should continue with her graduated return-to-work, [the Appellant] elected to do so.

By late July or early August, 1998, [the Appellant] again felt obliged to quit her return-to-work program, due to continuing, acute pain in her shoulder.

At different times in August 1998, both [Appellant's doctor #3] and [Appellant's physiotherapist] apparently expressed themselves as being somewhat baffled or confused by [the Appellant's] case. [Appellant's doctor #2] felt that she could return to her graduated return-to-work schedule, but did not want her lifting anything above her shoulders – not an easy restriction to impose on someone working in [text deleted] as a registered nurse.

On September 1, 1998 [Appellant's MPIC case manager] sent a somewhat minatory letter to [the Appellant], setting out a graduated return-to-work schedule which [the Appellant] had already agreed to attempt to follow, and pointing out that it was "imperative" that she comply with the program since failure to do so might result in suspension or termination of her benefits.

[The Appellant] resumed chiropractic treatments from [Appellant's chiropractor], whose report of September 10, 1998 describes right shoulder, neck and arm pain, inferior right shoulder, aberrant scapular motion and retraction, and diagnoses shoulder girdle and cervical dysfunction. Commenting that the patient's recovery seemed to have stalled, [Appellant's chiropractor] told [Appellant's MPIC case manager] on November 13th that he had advised the Appellant not to work, pending the results of her MRI. He expressed his feeling that "the source of this restricted motion needs to be diagnosed and resolved prior to attempting to work". [Appellant's doctor #1] appears to have agreed with that advice and, in consequence, [the Appellant] again quit her return-to-work program pending the outcome of her MRI. Meanwhile, in an attempt to explain the multiple difficulties she was experiencing at work, [the Appellant] wrote to [Appellant's MPIC case manager] and, amongst other matters, asked that an occupational therapist be sent to observe the actual nature of her work and the scarcity of so-called "light" duties. [Appellant's MPIC case manager] agreed to such an assessment and the services of [vocational rehab

consulting company #1] were retained to perform a physical demands analysis at [the Appellant's] workplace. [Appellant's MPIC case manager] also arranged for [text deleted], a vocational rehabilitation consultant with [vocational rehab consulting company #2] to assist [the Appellant] in securing employment, either as a registered nurse or in a different vocation commensurate with her qualifications.

[Appellant's vocational rehab consultant], on June 1, 1999, posed several written questions to [Appellant's orthopedic specialist #1] and, as well, to [Appellant's orthopedic specialist #2], another orthopedic specialist to whom [the Appellant] had been referred for a second opinion by [Appellant's doctor #1]. While most of [Appellant's orthopedic specialist #2's] responses to [Appellant's vocational rehab consultant's] questions are illegible, he and [Appellant's orthopedic specialist #1] were unanimous on these points:

- [the Appellant] was in no condition to return to her occupation as a registered nurse;
- there was a causal relationship between [the Appellant's] shoulder problems and her motor vehicle accident, although [Appellant's orthopedic specialist #2] qualifies that by saying, simply, "by history there is"; and
- surgical intervention was warranted.

A report from [Appellant's occupational therapist], of [vocational rehab consulting company #1], bearing date November 30, 1998 concluded that [the Appellant] should not be working in her pre-accident capacity – "If she does attempt to work she places herself and the [text deleted] at risk and she would likely see further regression as did occur following a previous attempt to gradually return-to-work in a supernumerary capacity". In the meantime, due to a breakdown in communication not attributable to the Appellant, [the Appellant] had missed a scheduled

appointment for her MRI and she was told that a new one could not be scheduled until March of 1999, adding to the Appellant's frustration. [Appellant's occupational therapist] recommended that the MRI be completed in [text deleted], North Dakota, where it could be done much more speedily; MPIC, upon the advice of [Appellant's doctor #2], did not approve that suggestion. The MRI was eventually rescheduled for [the Appellant] at [hospital #1] for February 15, 1999, where she was also booked for an arthrogram on March 5, 1999. That seems to have terminated the involvement of [vocational rehab consulting company #1] in [the Appellant's] case.

Meanwhile, [Appellant's doctor #1] had referred [the Appellant] for a second opinion to [Appellant's doctor #4], who saw her on January 12, 1999. He wanted to see the results of the MRI before making any recommendations, but merely said she should follow the advice of [Appellant's doctor #2].

The long-awaited Magnetic Resonance Imaging was performed on February 15, 1999, with results that [Appellant's doctor #2] described as "inconclusive but suspicious", resulting in the Appellant's referral to [Appellant's orthopedic specialist #1], an orthopedic specialist in shoulder, knee and sports injuries, with a view to having an arthroscopic examination of the Appellant's right shoulder. [Appellant's orthopedic specialist #1] operated on the Appellant on August 23, 1999, where she had "right shoulder arthroscopy, debridement of a partial thickness under surface rotator cuff tear, Type 1 superior labral fraying as well as an acromioplasty. [Appellant's orthopedic specialist #1], in a report to [Appellant's MPIC case manager] of September 27, 1999, concludes:

> Based on the information provided, it is conceivable that [the Appellant's] right shoulder condition was a result of the motor vehicle accident of April 2, 1997. There is both a temporal relationship and a consistency of physical findings related to arthroscopic findings. In addition, her condition has improved post-operatively and she stated at the first post-operative visit that her shoulder pain

was already better than it was pre-operatively.

Pending the surgery referred above, [the Appellant] volunteered on a regular basis at [hospital #2] in order to maintain her license as a registered nurse, but restricting her work to light duties; she was, concurrently, taking a counseling course with a view to obtaining employment in that capacity at her parish church. In early June, at the request of [Appellant's MPIC case manager], [Appellant's sports medicine specialist] had written out a series of questions for [Appellant's MPIC case manager] to ask [Appellant's doctor #2], which she did by letter of June 8th. We have to say that we are troubled by [Appellant's sports medicine specialist's] continued involvement in this case as an in-house consultant for MPIC when he had already been involved as a consultant to [the Appellant's] family physician.

On September 3, 1999, [Appellant's doctor #2] rendered a further report to [Appellant's MPIC case manager]. The significant portion of that report contains the following conclusion:

> While SLAP lesions have been described following motor vehicle collisions, the mechanism responsible usually involves contact between the involved shoulder and the interior of the vehicle. My records indicate that the claimant's mechanism of injury was a rear-end collision. Given the mechanism, the fact that the right shoulder was unrestrained and that her original presentation was largely inconsistent with rotator cuff tendonapathy, it is improbable that the current presentation with rotator cuff tendonapathy or SLAP pathology is causally related to date of loss of April 2, 1997.

[Appellant's MPIC case manager's] notes on file reflect that, on September 21, 1999, [Appellant's sports medicine specialist] had reviewed [Appellant's doctor #2's] report of September 3rd and had advised her to write to [Appellant's orthopedic specialist #1]. [Appellant's sports medicine specialist] "directed me as what questions I should be asking [Appellant's orthopedic specialist #1]. Once [Appellant's orthopedic specialist #1's] report is on

file, he will review further." Once again, we express our concern with the duality of [Appellant's sports medicine specialist's] rôles respecting [the Appellant's] claim.

Based primarily upon [Appellant's doctor #2's] report, concurred in by [Appellant's sports medicine specialist], [Appellant's MPIC case manager] wrote to the Appellant on November 4, 1999 to tell her that:

> In light of [Appellant's doctor #2's] medical evidence, no causal relation can be made between your current complaints and the injuries sustained as a result of your accident of April 2, 1997. As such, there is not entitlement to further income replacement indemnity benefits or physiotherapy treatment expenses. …. Your ….. benefits….. will be paid up to and including November 16, 1999.

[The Appellant] applied for a review of that decision. The Internal Review Officer confirmed it on March 2, 2000 and [the Appellant] now appeals to this Commission.

DISCUSSION:

It is well established that, when a stationary vehicle is rear-ended by another vehicle, the head of the driver or of a passenger in the first vehicle is likely to snap backwards in hyperextension while the rest of that person's body is propelled forward by the back of the seat. The amount of hyperextension will, of course, depend upon the existence and location of any head rest. That initial hyperextension is usually followed by a forward recoil or flexion, of which the extent will, again, depend upon a number of factors.

In the present case, the evidence of [the Appellant] has, from the beginning, been that at the time of the impact her right arm was fully extended forward and in contact with the front dashboard, where she was adjusting her car radio. [Appellant's doctor #2] is of the view that, since [the Appellant's] right shoulder was unrestrained and, since he believes her original presentation was inconsistent with rotator cuff tendonapathy, the shoulder problems that appear to have plagued

her from April 2, 1997 to the time of [Appellant's orthopedic specialist #1's] surgery and for several months thereafter could not, on a reasonable balance of probabilities, be attributed to her motor vehicle accident.

On the other hand, [Appellant's doctor #1] and [Appellant's chiropractor] are both of the view that the Appellant's shoulder problems were indeed attributable to her motor vehicle accident. [Appellant's orthopedic specialist #1] expresses the cautious view that it is certainly conceivable that the right shoulder condition was the result of that same accident and gives his reasons for that view. [Appellant's orthopedic specialist #2] says that, from the history given him by [the Appellant], as well as all of the medical information on file of which he had received copies from [Appellant's doctor #1], there is a causal relationship between the Appellant's shoulder problems and her MVA.

While this Commission is fully aware of the dangers of adopting a *post hoc, ergo propter hoc* approach to problems of this kind, the simple fact is that [the Appellant] has been voicing the same complaint with respect to her shoulder from almost immediately after her accident and had no prior history of any similar concern. She has been consistent; some of her medical caregivers have not. This last comment is not intended as a criticism of those caregivers; in some cases - this being one of them - even sophisticated diagnostic tools such as those that were brought to bear during the later months of her disability cannot replace the more invasive procedures to which [Appellant's orthopedic specialist #1] had recourse. It is unfortunate although not, perhaps, unusual, that [the Appellant] was receiving conflicting streams of advice throughout the period under review: [Appellant's doctor #2] and [Appellant's sports medicine specialist] were telling her to return to work and get used to living with her pain; [Appellant's doctor #1], [Appellant's orthopedic specialist #2], [Appellant's orthopedic specialist #1], [Appellant's doctor

#3] and [Appellant's chiropractor] and [vocational rehab consulting company #1's] evaluator were counseling her against return to work until the problem with her shoulder could be properly diagnosed and treated. [Appellant's doctor #4] saw her once only, and simply told her to do whatever [Appellant's doctor #2] told her to do. Following her surgery, she lost her original job at [text deleted] which had only been kept open for her until December 1, 1999. Fortunately, she has been able to find new employment in a supervisory capacity at [text deleted] at the end of January 2000. Since she now supervises the nursing staff of the entire building, if a patient needs to be lifted, she is able to get assistance from other staff personnel.

DISPOSITION:

We find, on a reasonable balance of probabilities, that the need for the surgery described earlier in these reasons arose, either in whole or in large part, from the motor vehicle accident in which the Appellant, [text deleted], was involved on April 2, 1997. It therefore follows that the Appellant is entitled to have her benefits reinstated from November 16, 1999 and, by virtue of Section 110(2)(d), to have her income replacement indemnity continued until the date in January, 2000 when she commenced employment at [text deleted].

Dated at Winnipeg this 23rd day of October, 2000.

J. F. REEH TAYLOR, Q.C.

YVONNE TAVARES

F. LESLIE COX