Automobile Injury Compensation Appeal Commission

IN THE MATTER OF an Appeal by [the Appellant]
AICAC File No.: AC-01-10

PANEL:	**Ms. Yvonne Tavares, Chairperson** **Ms. Laura Diamond** **Ms. Deborah Stewart**
APPEARANCES:	**The Appellant, [text deleted], appeared on her own behalf; Manitoba Public Insurance Corporation ('MPIC') was represented by Mr. Dean Scaletta.**
HEARING DATE:	**October 17, 2001**
ISSUE(S):	**(i) Termination of Income Replacement Indemnity benefits;** **(ii) Termination of coverage for treatment expenses.**
RELEVANT SECTIONS:	**Sections 81(1) and 136 of *The Manitoba Public Insurance Corporation Act* (the "MPIC Act") and Section 5 of Manitoba Regulation 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

The Appellant, [text deleted], has had an unfortunate history of involvement in motor vehicle accidents - having been involved in at least six accidents since late 1989. The written documentation provided to the Automobile Injury Compensation Appeal Commission details that [the Appellant] was involved in motor vehicle collisions on December 19, 1989 and January 17, 1990. Based on the information provided in the medical reports following these collisions, it appears that [the Appellant] sustained musculotendinous injuries as a result of these collisions.

[independent doctor] conducted an Independent Medical Examination of [the Appellant] on May 24, 1990. He noted in a report dated May 29, 1990, that [the Appellant] would not develop any permanent disability as a result of the strain she sustained in these motor vehicle collisions.

[The Appellant] attended her general practitioner, [text deleted], for follow-up examinations throughout 1991, and it was noted that [the Appellant's] response to treatment was slow but progressive. In a report dated October 4, 1994, [Appellant's doctor #1] documented that [the Appellant] had *"completely recovered"* from the medical conditions arising from the 1989 and 1990 motor vehicle collisions.

[The Appellant] was involved in two further motor vehicle collisions, one occurring on September 24, 1994, and the other on March 10, 1995, at which time she was rear-ended by another vehicle. From the reports submitted by [Appellant's doctor #1], [Appellant's doctor #2] and [Appellant's doctor #3], it appears that [the Appellant's] symptoms were once again musculotendinous in origin (i.e., myofascial). [The Appellant] presented to these physicians with neurological symptoms (i.e., numbness involving her left upper extremity), but no neurological abnormalities were noted. [The Appellant] received physiotherapy treatments as well as chiropractic adjustments for her symptoms, although it was noted in the medical reports that [the Appellant] did not improve with the chiropractic treatments she received for her symptoms arising from these motor vehicle collisions.

[The Appellant's] situation is complicated by a history of chronic and severe asthma dating back to childhood. She has been hospitalized on numerous occasions for exacerbations of her asthma. Prior to the most recent motor vehicle collision, [the Appellant] was taking Flovent, Ventolin and Prednisone to control her symptoms. [The Appellant] was employed as a substitute teacher for

various school divisions as well as a part-time salesperson with [text deleted] up until April 18, 1997.

The medical information in her file indicated that [the Appellant] had not fully recovered from the 1995 motor vehicle collision prior to being involved in a motor vehicle collision on February 20, 1997, wherein she sustained a whiplash injury and lumbar mechanical back strain. She was initially treated with Tylenol #3 for pain control and referred to physiotherapy. She was then involved in a subsequent motor vehicle accident on April 18, 1997. According to her attending physician, [text deleted], prior to the motor vehicle accident of April 18, 1997, the Appellant continued to complain of pain and stiffness in the neck and lower back. Examination just prior to the April 18th accident displayed widespread tenderness of the cervical, thoracic and lumbar spine. Range of motion of the cervical and lumbar spine was decreased in all directions.

[The Appellant's] motor vehicle collision on April 18, 1997 occurred when her vehicle was rear-ended by a second vehicle. The first health care report relating to this accident was submitted by [Appellant's doctor #4] dated April 28, 1997. In this report he documented the presence of tender muscles over the cervical and lumbar region, as well as decrease of spinal movements. It was [Appellant's doctor #4's] opinion that [the Appellant] had sustained an *"acute on chronic whiplash"* and *"lumbar mechanical back strain"*. [Appellant's doctor #4] prescribed daily physiotherapy. A follow-up report dated May 30, 1997, documented no significant change in [the Appellant's] condition, and it was noted that [the Appellant] was referred to [Appellant's physiatrist]. In a report dated October 10, 1997, [Appellant's doctor #4] documented that a referral to the [text deleted] Clinic would not be useful for [the Appellant]. It was also [Appellant's doctor #4's] opinion, which he documented in a February 10, 1998 report, that she was unable to return to her work as a result of *"MVA-related injuries"*.

In the physiotherapist's report dated April 27, 1997, it is documented that [the Appellant] was very sensitive to light touch during the examination. Decrease in spinal range of motion was noted, and it was the opinion of the physiotherapist that [the Appellant] had multiple soft-tissue injuries.

[Appellant's physiatrist] assessed [the Appellant] on May 29, 1997. In [Appellant's physiatrist's] report outlining his clinical findings, dated May 31, 1997, he documented that the soft tissues of the neck region were very sensitive to touch as well as a limitation of cervical and lumbar range of motion. He did not document any neurological abnormalities. It was [Appellant's physiatrist's] opinion that [the Appellant] had a *"chronic soft-tissue pain syndrome with mild weakness in the muscles of both legs"*. [Appellant's physiatrist] recommended a variety of blood tests and radiological examinations to be carried out. In a follow-up report dated July 17, 1997, it was [Appellant's physiatrist's] opinion that [the Appellant] was unable to return to her previous occupation as a result of her pain, restriction of movements of the spine, weakness and reduced functional capabilities. It was his recommendation that [the Appellant] continue with her home exercises and medication to minimize her symptoms.

In a subsequent report dated September 2, 1997, [Appellant's physiatrist] documented that [the Appellant's] examination still revealed limited cervical and lumbar range of motion although the overall mobility of her spine had increased. [Appellant's physiatrist] recommended that she try desensitization of the soft tissues, follow the general principles of muscle relaxation and increase her activities as tolerated. There was also documentation of two hospitalizations [the Appellant] required for treatment of her asthma.

[Appellant's physiatrist] reassessed [the Appellant] on November 21, 1997, and January 16, 1998. It was his recommendation that [the Appellant] undergo further investigations and continue with her home spinal mobilization and stretching exercises. He did document that [the Appellant's] mild skeletal muscle weakness was in part a result of her injuries and partially due to her high dose of Prednisone therapy she was taking for asthma. He also noted that [the Appellant] was developing symptoms of a *"reactive depression"* and that she had seen a psychiatrist for these symptoms. It was [Appellant's physiatrist's] recommendation that [the Appellant] receive a six- to eight-week comprehensive rehabilitation program, which included physiotherapy, psychological counselling, and a Functional Restoration Program. He was hopeful that the treatment would assist [the Appellant] in minimizing her pain and improve her functional level to the point that she could be encouraged to return to work at her previous capacity. [Appellant's physiatrist's] opinion regarding [the Appellant's] inability to work was based on the presence of *"restriction of movements of the spine, soft-tissue tenderness, mild weakness of the skeletal muscles, spinal stiffness, headaches, and low endurance to do any light to medium work and activities"*.

Throughout this time, [Appellant's respiratory specialist] was treating [the Appellant]'s respiratory condition. In a report dated February 4, 1998, [Appellant's respiratory specialist] documented that [the Appellant]'s asthma was under control but felt that exposure to cold temperatures and supervising activities in a gym may cause her some respiratory problems. It was [Appellant's respiratory specialist]'s opinion that [the Appellant's] respiratory condition at that time would not preclude her from an active rehabilitation program. It was also [Appellant's respiratory specialist's] opinion that [the Appellant's] life-threatening asthmatic attacks did not take place as a result of the previous motor vehicle accidents.

[The Appellant] underwent an examination at the [rehab clinic] on March 16, 1998 to determine if she was a candidate for a reconditioning program. This assessment was carried out by [text deleted], physiotherapist and [text deleted], psychologist. [Appellant's physiotherapist #1] reviewed [the Appellant's] subjective complaints, her past medical history, and the reports of [Appellant's physiatrist]. [Appellant's physiotherapist's] examination of [the Appellant] revealed limitation of spinal movements, multiple areas of tenderness, positive Waddell signs, but no evidence of neurological dysfunction. [Appellant's physiotherapist #1] documented his clinical findings in a report dated March 18, 1998, and it was his opinion that [the Appellant's] assessment revealed a number of inconsistencies. He also outlined in his report [Appellant's psychologist's] comments pertaining to her examination of [the Appellant]. [Appellant's psychologist #1] noted that [the Appellant] was "*polite but remote in her interactions"* and added that the client is "*currently presenting with signs of significant somatizing tendencies but also inconsistency/exaggeration."* [Appellant's psychologist #1] was of the opinion that [the Appellant] was not a good candidate for a work hardening or reconditioning program without first having her depression addressed. [Appellant's physiotherapist #1] documented that it was the assessment team's opinion that [the Appellant] was not an appropriate candidate for a rehabilitation program at that time. It was the team's recommendation that [the Appellant] undergo an Independent Medical Examination in order to delineate the client's diagnosis and outline expectations for rehabilitation participation, as well as see a psychologist to address her depression. They also recommended that [the Appellant] follow up with her family doctor in order to review her antidepressant medication.

Following on the recommendation of the team from the [rehab clinic], [independent doctor] performed an Independent Medical Examination of [the Appellant] on June 12, 1998. He documented his findings in a report dated June 22, 1998. [Independent doctor] reviewed [the

Appellant's] history, as well as the treatments she received and the investigations performed. An examination of [the Appellant] identified limitation of cervical and lumbar range of motion as well as a slight decrease in left shoulder movements. His examination also identified pain with internal hip rotation. The neurological examination revealed mild muscle weakness, but it was his opinion that this was *"effort limited"*. It was [independent doctor's] opinion that [the Appellant] had the following diagnoses: (1) Chronic pain syndrome; (2) Major affective disorder – depression; (3) Ankylosing spondylitis; (4) Somatization disorder; and (5) Symptom magnification.

[Independent doctor] documented that: *"Based upon the available information, to a reasonable degree of medical certainty, there is a causal relationship between the current symptoms and the multiple motor vehicle accidents reported"*.

[Independent doctor] also commented on [the Appellant's] impairment of function and indicated that an impairment was present secondary to the following: (1) Dysthymic mood; (2) Non-uniform loss of range of motion in her cervical and lumbosacral spine; and (3) Non-uniform loss of range of motion in her left shoulder and both hips.

[Independent doctor]'s documentation pertaining to disability outlined [the Appellant's] results of questionnaires completed, which identified a high perceived level of disability. As an estimate, her perception of disability was 70-80%. [Independent doctor] outlined that [the Appellant's] prognosis for complete symptom resolution was *"very poor"* and that the prognosis for functional improvement was *"guarded"* due to the apparent *"psychological overlay and depression"*.

With regards to work capacity, [independent doctor] noted that it was very difficult to reliably predict the claimant's capability at work given her symptom magnification and psychological overlay. However, he indicated that from a physical point of view, [the Appellant] was capable of performing sedentary to light work capacity. He was uncertain as to when [the Appellant] would be capable of returning to her work as a substitute teacher, but he noted that her *"inattentiveness, hyper-irritability, decreased concentration and general depressed mood"* were major barriers preventing her from returning to her previous work capacity. It was [independent doctor's] recommendation that [the Appellant] obtain further counselling from a psychologist and continue receiving treatments from her psychiatrist for her major affective disorder. It was his opinion that a reconditioning program/work-hardening program would not be appropriate nor successful for her at that time. He was of the opinion that [the Appellant's] motivation with regard to performing home exercises was a *"major problem"* and, with this in mind, he felt that physiotherapy treatments three times per week would be appropriate.

In a report submitted by [Appellant's doctor #4] dated July 24, 1998, he documented that [the Appellant] was assessed by [text deleted] (Rheumatologist) who was not convinced that she had ankylosing spondylitis.

[Appellant's psychologist #1] had the opportunity of reassessing the Appellant on September 8, 1998 regarding her suitability for the work hardening program at the [rehab clinic]. In her report, [Appellant's psychologist #1] noted that the Appellant's status did not appear to have changed appreciably since she had first interviewed her. [the Appellant] remained significantly depressed and her motivation to participate in programming was all but nonexistent, likely owing to low levels of energy and fearfulness and pessimism regarding her physical capabilities. She recommended that [the Appellant] be provided with the services of a psychologist and a

physiotherapist who could work in conjunction with one another and with [text deleted] (her psychiatrist) to systemically address the physical and psychological problems experienced by the Appellant.

The Appellant was subsequently assessed by [text deleted], a physiotherapist, in order to commence a graduated functional exercise program. Based upon her physical examination and interview with [the Appellant], [Appellant's physiotherapist #2] noted that [the Appellant] was disabled to an extreme degree, she was pain focused and pain limited. She outlined a program for the Appellant to undertake in conjunction with treatment for the psychological component of her chronic pain state. A referral to Cognitive Behavioural Therapy with [Appellant's psychologist #2] was undertaken to provide treatment for pain management.

A team meeting was held on October 28, 1998 with several of [the Appellant's] caregivers in attendance, as well as her rehabilitation consultant, her case manager from MPIC and [MPIC's doctor] of MPIC's Health Care Services Team. The purpose of the team meeting was to introduce the various team members to one another and to formulate a rehabilitation plan for the Appellant. At the meeting, [Appellant's respiratory specialist] reported that [the Appellant's] respiratory status was not very good and it was his opinion that [the Appellant] would be unable to resume her previous occupations. He also stated that [the Appellant] would be unable to engage in any cardiovascular exercise programs but would be able to perform range of motion and stretching exercises. He outlined that [the Appellant] would have a difficult time attending a therapy service on a regular basis as a result of her asthma condition, but he approved of having a therapist attend at the Appellant's residence to go over various exercises with her.

Based on the outcome of the team meeting, the Appellant's case manager wrote to the Appellant on November 20, 1998 to advise her that since she was unable to comply with her rehabilitation program due to her pre-existing asthma, there was no alternative but to suspend income replacement indemnity benefits until such time as she was able to participate in a rehabilitation program. She was further advised that once her asthmatic condition stabilized to the point where she was able to participate in a rehabilitation program, the issue of income replacement indemnity benefits would be revisited.

The Appellant filed an Application for Review of that decision. At or about the same time, the Appellant also filed an application for Canada Pension Plan disability benefits based upon her acute asthma. Canada Pension Plan disability benefits were subsequently approved for the Appellant and she is currently in receipt of benefits pursuant to that program.

In a decision dated November 18, 1999, the Internal Review Officer determined that the Appellant had a valid reason for not participating in the rehabilitation program due to her asthmatic condition. The Internal Review Officer overturned the case manager's decision and reinstated her benefits.

The file was subsequently referred to [text deleted], Medical Consultant of the MPIC Claims Services Department, for review to determine whether or not her persistent symptomatology was causally related to the motor vehicle collision. The review was also performed to determine whether or not the objective clinical findings identified a medical condition arising from the motor vehicle collision in question, which in turn would benefit from further therapeutic interventions.

[MPIC’s doctor] concluded that based on the clinical findings identified by the healthcare professionals involved in [the Appellant's] care following the April 18, 1997 motor vehicle collision, it appeared that [the Appellant] exacerbated her pre-existing chronic pain syndrome. He found that there was insufficient documentation objectively identifying a pathophysiological condition involving [the Appellant's] spine, soft tissue and/or neurological structures, which developed as a direct result of the motor vehicle collision in question.

In a letter dated September 12, 2000, MPIC's case manager wrote to the Appellant to advise her that the medical information on her file did not establish a cause/effect relationship between her present condition and the motor vehicle accident of April 18, 1997. The medical information on the Appellant's file indicated that there were a number of unrelated medical conditions precluding her ability to return to work. According to MPIC's Health Care Services Team, none of these conditions arose from the motor vehicle accident of April 18, 1997. Accordingly, there were no conditions arising from the motor vehicle accident precluding her return to the jobs she held at the time of the motor vehicle accident. Therefore, the letter advised that effective September 29, 2000, the Appellant's entitlement to income replacement indemnity benefits as well as her entitlement to any other Personal Injury Protection Plan ('PIPP') benefits would cease.

The Appellant sought an internal review of that decision. In her Application for Review of Injury Claim Decision dated September 21, 2000, the Appellant asserted that was indeed a causal connection between her disabling medical conditions and the motor vehicle accidents in which she had been involved. She claimed that the motor vehicle accidents had contributed significantly to her present status and requested that her PIPP benefits be reinstated.

In a decision dated January 15, 2001, the Internal Review Officer upheld the case manager's decision of September 12, 2000 and dismissed the Appellant's Application for Review. After a careful review of the medical information on file, the Internal Review Officer concluded that there was not a causal relationship between the Appellant's present condition(s) and the motor vehicle accident, which would justify continuing payment of income replacement indemnity benefits beyond September 29, 2000. The Internal Review Officer also based his decision on [MPIC's doctor's] conclusion that the accidents in question had in all probability ceased playing a causative role in the Appellant's ongoing symptomatology.

The Appellant filed a Notice of Appeal on January 30, 2001 with this Commission seeking an appeal of the Internal Review Officer's decision of January 12, 2001. The Appellant is seeking reinstatement of her income replacement indemnity benefits from September 29, 2000, and reinstatement of treatment benefits.

The Law:

The relevant sections of the MPIC Act for the present appeal are:

Section 81(1) of the MPIC Act provides that:

> **Entitlement to I.R.I.**
> **81(1)** A full-time earner is entitled to an income replacement indemnity if any of the following occurs as a result of the accident:
>
> (a) he or she is unable to continue the full-time employment;
>
> (b) the full-time earner is unable to continue any other employment that he or she held, in addition to the full-time regular employment, at the time of the accident.

Section 136 of the MPIC Act provides that:

> **Reimbursement of victim for various expenses**
> **136(1)** Subject to the regulations, the victim is entitled, to the extent that he or she is not entitled to reimbursement under *The Health Services Insurance Act* or any other Act, to the reimbursement of expenses incurred by the victim because of the accident for any of the following:
>
> (a) medical and paramedical care, including transportation and lodging for the purpose of receiving the care;

Section 5 of Regulation 40/94 provides that:

> **Medical or paramedical care**
> **5** Subject to sections 6 to 9, the corporation shall pay an expense incurred by a victim, to the extent that the victim is not entitled to be reimbursed for the expense under *The Health Services Insurance Act* or any other Act, for the purpose of receiving medical or paramedical care in the following circumstances:
>
> (a) when care is medically required and is dispensed in the province by a physician, paramedic, dentist, optometrist, chiropractor, physiotherapist, registered psychologist or athletic therapist, or as prescribed by a physician.

Discussion:

The issue which requires determination in the current appeal is whether or not there exists a causal connection between the Appellant's current condition and the motor vehicle accidents which occurred after March 1, 1994. The relevant sections of the legislation are clear that in order to receive either income replacement indemnity benefits or treatment benefits, an ongoing relationship to the motor vehicle accident must be established.

The Appellant suffers from three disabling conditions: asthma, depression and chronic soft tissue pain syndrome.

Asthma

The Appellant has had a history of chronic and severe asthma since childhood. The asthma has progressively worsened over the past several years, to the point where the Appellant has required

multiple medications as well as admissions to hospital due to this condition.

In his Inter-departmental Memorandum of October 28, 1998, [MPIC's doctor] notes the following:

> From the meeting that was held on October 23, 1998, it is my understanding that [the Appellant's] respiratory status is not very good. [Appellant's respiratory specialist] outlined that [the Appellant] has severe asthma and is probably one of the more severe cases he had ever managed. He stated that [the Appellant's] flow rates in the past were around 50% but as of late they have dropped down to 30-40%. It was [Appellant's respiratory specialist]'s opinion that with these flow rates, [the Appellant] would be unable to resume her previous occupations. He also stated that [the Appellant] would be unable to engage in any cardiovascular exercise programs but would be able to perform range of motion and stretching exercises. He outlined that [the Appellant] would have a difficult time attending a therapy service on a regular basis as a result of her asthma condition. At times her asthma is quite severe to the point where she is unable to leave her home and therefore would not be able to attend therapy.

In a letter to the case manager dated February 4, 1998, [Appellant's respiratory specialist] made the following comments:

> Her asthma has been somewhat severe and can be precipitated by a number of causes usually acute bronchitis but I do not feel that her life-threatening exacerbation has been caused by the previous auto accidents that have occurred. In addition, due to her soft tissue symptoms she has been prescribed Tylenol #3, Flexeril, and prednisone, and these medications should not contribute to the worsening of her asthma.

Depression

The medical reports suggest that the Appellant's depression preceded her 1997 motor vehicle accidents, although the depression appears to have had its onset after the motor vehicle accident of March 10, 1995. The Appellant was initially diagnosed with depression by [text deleted], psychiatrist. The Appellant had been referred to [Appellant's psychiatrist] by her family

physician for an assessment regarding her depression. In his letter dated October 8, 1997, [Appellant's psychiatrist] reported the following:

> This patient presents with a greater than one year history of depression. She indicates a depressed mood, a loss of interest, and motivation. Her sleep is disturbed by middle insomnia and she typically sleeps only 2-3 hours per night and 3 hours per day. She indicates daily crying spells, loss of appetite, and a lack of energy. She indicates cognitive difficulties in the form of poor short term memory, and poor concentration. Despite these depressive symptoms, she reports feeling optimistic and hopeful. She denied any suicidal ideations.
> …
>
> IMPRESSION
>
> I feel this patient has a diagnosis of a chronic pain syndrome and major depression.
>
> In terms of treatment, she may benefit from anti-depressant therapy with a SSRI, such as paxil 20-40 mg per day. Paxil is also somewhat sedating so it may also help her sleep disturbance. She may further benefit from cognitive therapy, as an adjunct to her pharmacotherapy.

[Appellant's psychiatrist] reassessed the Appellant on June 15, 1998. His report of the same date notes the following:

> Her previously documented depression has not significantly changed since I last saw her. She indicated the Paxil was of no help. About two months ago, she was started on Zoloft 50 mg per day, later increased to 100 mg per day, resulting in what she feels has been the best antidepressant so far. Nevertheless, she indicates her mood is depressed. Her energy is poor. She lacks motivation and interest. Her sleep is severely disturbed by middle insomnia, secondary to her pain, resulting in a total sleep of no more than 2-3 hours per night. Her short term memory and concentration are both poor. Her appetite is variable. Her crying spells have lessened as compared to before. She denied any suicidal ideations. She denied feeling angry or irritable. Mostly, she indicated feeling "fed up" and discouraged". She is acutely aware her condition is not improving and she seems to be losing hope that it will improve in the future. She feels nothing is going right for her and whatever news she may hear will be bad. Overall she feels she is coping less well than previously.
> …
> I feel this patient continues to have a diagnosis of a Chronic Pain

> Syndrome and a Major Depression. Because of the lack of perceived improvement, she is starting to lose hope, feel frustrated, and feel discouraged. This negative attitude may be part of her depression and/or a negative psychological attitude towards her chronic pain condition.

In a letter dated June 24, 1999, [Appellant's psychiatrist] makes the following comments:

> [The Appellant] has been in multiple motor vehicle accidents in the past 5-6 years and, as a result, she has been suffering from chronic pain, especially in her neck, both shoulders, hr back, and her knees. The level of pain has not improved over this period of time and continues to be very problematic and disabling for her. To complicate matters, she also suffers from severe asthma. [Appellant's respiratory specialist] looks after her for this and he has hospitalized her many times during this period of time because of acute exacerbations. This severe asthma also interfered with rehabilitation efforts with regards to her chronic pain disorder.
>
> There is also a 3 year history of depression which has not significantly improved despite treatment. Her mood is severely depressed and her affect is flat. She has frequent crying spells. She indicates no interest and no motivation. She is anergic. Her sleep is fragmented and disturbed. She indicates feelings of discouragement and hopelessness. Her level of functioning is reported poor due to her medical and pain condition. She consistently denies any suicidal ideations. There are no psychotic features.

[Appellant's psychiatrist] referred the Appellant to cognitive group therapy with [text deleted], a clinical psychologist. [Appellant's psychologist #2], in a letter dated October 19, 1998, noted the following about the Appellant based on a brief half-hour interview:

> My impression is that there is significant psychological aspects to her state, and that they are paramount. My immediate impression was that she was exaggerating problems in order to obtain some secondary gain, such as sympathy. It may be that she wants others to feel that something is wrong. She also may want to make it difficult for others. This exaggeration is probably not conscious or purposeful, but seems to reflect a subconscious need beyond her awareness. She impressed as possessing chronic anger which she appears syntonic with, that is, she does not appear ready to be aware of, acknowledge and reflect on same, possibly because of the payoff it brings.
>
> She said that she was depressed, that her present life was "just an existence." She reported concentration problems when reading. No real depressive affect was apparent, although depressive feelings appear to be associated with her chronic pain. At this early point it is not clear if she

> experiences bonafide clinical depression.

In a letter dated January 12, 1999, [Appellant's psychologist #2] commented on the progress of the Appellant in the Cognitive Therapy Group Program for Depression. He noted that:

> At our last contact she continued to be significantly depressed, showing many depressive negative thoughts as well as depressed affect. However, she was no longer reticent, wary or skeptical of the Group or the therapy process and was somewhat improved.
>
> Although her health, particularly the severe asthma condition, contributes significantly to the depression, the MVA plays a significant role. In many individuals, when there are a number of stressors compounding on each other, the increased helplessness brought upon by the compounding of stressors plays a significant role in inducing the depression. The MVA was a significant role in starting this cycle. The helplessness she felt in her accident, and the resulting depression, appeared to have played a significant role in inducing a weakened condition and a helpless, lethargic state which contributed to the symptomatology of the asthma and in compounding the depression. The asthma does not exist independently of the other factors. It has significant psychosomatic components. In this way, the MVA plays a significant role in the clinical picture, by starting the process which induced the helplessness and lethargy.

Chronic Soft Tissue Pain Syndrome

The onset of the depression is also clearly linked to the chronic pain which the Appellant developed shortly before the 1997 motor vehicle accidents. [Text deleted], clinical psychologist, had assessed the Appellant on December 23, 1996, at which time [the Appellant] was 21 months post-injury, having been involved in the MVA on March 10, 1995. In his report dated January 26, 1997, [Appellant's psychologist #3] makes the following comments:

> The results of this assessment suggest that [the Appellant] has been coping well with her current conditions, likely through engaging in work-related activities and keeping herself busy in the home. [The Appellant] presented as an individual who has always been independent and self-reliant and as a result, likely experiences offers of help from other professionals as somewhat intrusive and perhaps threatening to her own self-reliance. Obviously, for treatment to be effective this issue would have to be dealt with and overcome in a mutually collaborative manner. I do believe that given enough time, [the Appellant] would be capable of

> forming a therapeutic alliance and through such an alliance, developing a greater awareness of chronic pain issues as well as gaining a better understanding of the role that she plays and the power that she has over her condition. Therefore, I would recommend pain management counseling for [the Appellant], with a focus of such counseling on improving her sleep through instruction in sleep hygiene, as well as focusing on the ways in which [the Appellant] engages in pain management. No specific psychological pain management techniques were reported, and the vast majority of the techniques reported were quite passive. I believe that with appropriate education, [the Appellant] would be able to integrate more active and psychologically-based pain management strategies into her behavioral repertoire, and by doing so both reduce her subjective perceptions of her pain as well as increase the perception of control that she has over her life. I believe that both of these benefits would likely lead to an increased level of functioning on her part.

The Appellant, in her testimony before the Commission, explained that she had always struggled with some residual pain in her shoulders, neck and back from her motor vehicle accidents prior to the April 18, 1997 accident. It is also documented in various reports that [the Appellant] was experiencing chronic soft tissue pain prior to the 1997 motor vehicle accidents. [Appellant's physiatrist] first diagnosed the Appellant as suffering from chronic soft tissue pain syndrome with mild weakness in the muscles of both legs based on his examination of the Appellant on May 29, 1997. Based on the information obtained from [Appellant's physiatrist's] reports, it appears that the collisions in 1997 worsened her symptoms. As a result of the chronic pain, [the Appellant's] function was limited as far as household and work activities. [The Appellant] received various treatment interventions to address the chronic soft tissue pain in the form of medications, injections, exercises and physiotherapy. [The Appellant's] response to treatments varied, but overall no significant improvement was identified. In his report dated August 14, 2001, [Appellant's physiatrist] summarizes the Appellant's continuing condition as follows:

> In summary, [the Appellant] continues to have persistent neck, back, shoulder and hip pains, and clinical presentation of fibromyalgia and soft tissue pain syndrome, most likely resulting from the trauma she suffered in the motor vehicle accident. She has not made any significant improvement in spite of analgesics, non-steroidal anti-inflammatory drug therapy, muscle relaxants, physiotherapy and spray and stretch treatments.

> It is unlikely that she will make any further significant improvement in her symptomatology and in her functional level.

As previously noted, the issue which requires determination in this matter is one of causation. The Internal Review Officer at page 7 of his decision dated January 15, 2001, framed the issue as whether the totality of the medical evidence establishes the requirement for the ongoing payment of IRI beyond September 29, 2000 on account of injuries arising out of the accidents in question. In rendering his decision he relied, in part, on the following analysis of the Appellant's condition by [MPIC's doctor] (from his Inter-departmental Memorandum dated January 18, 2000):

> An exacerbation of a pre-existing medical condition results in a temporary increase in symptoms without altering the natural course of the condition. In other words, an exacerbation will resolve with time. It is now almost three years since the MVC. This is ample time for an exacerbation to fully resolve even in the absence of therapeutic interventions. [The Appellant] received a fairly comprehensive treatment program following the MVC (i.e. physiotherapy, psychological support, pharmacological assistance and education with regard to home exercises). It is reasonable to conclude, based on the balance of medical probabilities that the exacerbation [the Appellant] likely experienced as a result of the MVC has fully resolved. There is insufficient objective medical evidence to indicate that it did not.

Conclusion

The Commission finds that as a result of the asthma, the depression and the chronic soft tissue pain syndrome, [the Appellant] has a physical and psychological impairment of function, which in turn totally disables her from performing any occupational duties. After a careful review of all of the relevant information made available to this Commission, we are unable to establish a causal connection between these ongoing conditions and the motor vehicle accidents which occurred after March 1, 1994. Although the Appellant may have initially been unable to return to work after her latest motor vehicle accident on April 18th, 1997, due to the injuries resulting from that accident, we find that certainly by September 29th, 2000, the effects of those injuries have been overtaken by her asthmatic condition and its effects, to the extent that the asthma was

and continues to be the primary disabling condition. It is the asthma which lead to her inability to participate in a rehabilitation program, which perpetuates the deconditioned physical state and her chronic soft tissue pain syndrome and which in turn leads to her continued depression.

Accordingly, for these reasons, the Commission dismisses the Appellant's appeal and confirms the decision of MPIC's Internal Review Officer bearing date January 15, 2001.

Dated at Winnipeg this 26th day of February, 2002.

YVONNE TAVARES

LAURA DIAMOND

DEBORAH STEWART