Manitoba

Automobile Injury Compensation Appeal Commission

IN THE MATTER OF an Appeal by [the Appellant]
AICAC File No.: AC-03-64

PANEL:	**Mr. Mel Myers, Q.C., Chairperson** **Mr. Paul Johnston** **Mr. Les Marks**
APPEARANCES:	**The Appellant, [text deleted], was represented by Mr. Robert Sample, Claimant Adviser Office;** **Manitoba Public Insurance Corporation ('MPIC') was represented by Ms Dianne Pemkowski.**
HEARING DATE:	**November 25 and 26, 2008**
ISSUE(S):	**Entitlement to Personal Injury Protection Plan benefits respecting the Appellant's cardiac condition (is there a probable cause/effect relationship between the Appellant's cardiac condition and the motor vehicle accident).**
RELEVANT SECTIONS:	**Section 136(1) of The Manitoba Public Insurance Corporation Act ('MPIC Act') and Section 5(a) of Manitoba Regulation 40/94.**

AICAC NOTE: THIS DECISION HAS BEEN EDITED TO PROTECT THE PERSONAL HEALTH INFORMATION OF INDIVIDUALS BY REMOVING PERSONAL IDENTIFIERS AND OTHER IDENTIFYING INFORMATION.

Reasons For Decision

[The Appellant] [text deleted] was involved in a car-pedestrian accident on April 21, 1998. He was 66 years of age at that time and retired. The injuries he sustained in the accident included multiple bruising over his body, four fractured ribs, left ankle strain, massive bruising of abdominal-chest area, massive scrapes-type injuries to the right hand and left knee, a concussion, a slight internal bleed of the right side of the brain. As a result of the motor vehicle accident

injuries the Appellant received a permanent impairment award for: (a) four fractured ribs (b) traumatic brain injury [(c)] disfigurement affecting the elbow, right hand, lower limbs, neck and face.

The case manager wrote to the Appellant on February 9, 2001 and indicated that MPIC covered the treatment expenses incurred as a result of the bodily injuries sustained in the motor vehicle accident. The case manager however concluded, based on medical information from [Hospital #1] and [Appellant's Cardiologist #1], that the Appellant's cardiac condition was not related to the motor vehicle accident and as a result MPIC was unable to provide coverage for any expenses associated with the cardiac condition.

The Internal Review Decision

The Appellant filed an application for review dated September 25, 2002. On January 30, 2003 the Internal Review Officer issued a decision confirming the case manager's decision and dismissing the Appellant's application for review. Based on the medical reports of [Appellant's Cardiologist #1], and the reports of MPIC's medical director, [MPIC's Doctor], the Internal Review Officer concluded that there was no causal relationship between the motor vehicle accident and the Appellant's cardiac condition. As a result the Internal Review Officer rejected the Appellant's request for reimbursement of treatment costs and associated travel costs related to his heart condition.

In his decision the Internal Review Officer reviewed a report from [Appellant's Cardiologist #1] dated May 23, 2000 who concluded that there was no causal relationship between the Appellant's motor vehicle accident and his heart condition. The Internal Review Officer stated:

> In that report [Appellant's Cardiologist #1] indicated that he assessed you in July, 1998 as a result of recurrent chest pain. As a result of ongoing chest pain you reattended for reevaluation by [Appellant's Cardiologist #1] in January, 2000. [Appellant's Cardiologist #1] states therein with respect to that reattendance:
>
> "This patient returned recently from my re-evaluation because of the ongoing chest pain. As a result I have elected to request Myocardial Perfusion Study (stress Sestamibi test) which to my surprise turned out to be positive with reversible defect in anterior, lateral wall, as well as apex".
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> As to provide his opinion as to whether the condition was related to the motor vehicle accident, [Appellant's Cardiologist #1] states:
>
> "In response to your question regarding common cause of his condition-it represents a clinical puzzle. ECG pattern and perfusion scan are in keeping with myocardial infarction/myocardial ischemia, but on the other hand a cardiogram echocardiogram and MUGA scan did not document wall motion abnormalities. It is possible that this man is suffering from coronary artery disease, but alternative explanation still could be commotio cordis as a result of trauma to the chest."
>
> [Appellant's Cardiologist #1] concluded his report by indicating that you were sent for a coronary angiography which would provide the further answer to the cause of the condition.
>
> In a follow-up report dated June 9, 2000 from [Appellant's Cardiologist #1] enclosed a CT scan which ruled out traumatic disruption/aeortic injury. It was [Appellant's Cardiologist #1's] diagnosis therein that you were suffering from "commotio cordis".
>
> A follow-up request was made of [Appellant's Cardiologist #1] to provide an opinion with respect to the relationship of the accident to your condition. In his report of June 23, 2000, [Appellant's Cardiologist #1] stated:
>
> "Based on available (or in fact lack of) data, one cannot conclude without absolute certainty what it (sic) the relation between this patient's apparent myocardial infarction and MVA. (underlining added) …

The Internal Review Officer also referred to the reports of [MPIC's Doctor], who concluded there was no causal relationship between the motor vehicle accident and the Appellant's problems. The Internal Review Officer stated:

> In an Inter-Departmental Memorandum of July 17, 2000, [MPIC's Doctor] discussed whether the condition of commotio cordis was related to the accident. In that regard [MPIC's Doctor] provided a Medical Causality Assessment dated July 17, 2000 in which he concluded:

> "The temporal sequence of events in [the Appellant's] case, appears to indicate that he originally had MUGA scanning an (sic) echocardiography which failed to reveal left ventricular dysfunction. He subsequently manifested evidence of left ventricular dysfunction after being seen in 1998. This seems to indicate that there was a progressive decline in his cardiac status in the two years between 1998, and the present.
>
> At this time, in my opinion, there is not a medically probable cause relationship between the collision in question, and [the Appellant's] (sic) cardiac condition. He does not have evidence of commotion (sic) cordis, on the balance of probability. He appears to have evidence of proximal left anterior descending coronary artery occlusive disease with significant left ventricular dysfunction. There is not a medically probable causal relationship between this condition, and trauma in question". (underlining added)

In an interdepartmental memorandum dated December 29, 2000 [MPIC's Doctor] reported to MPIC in which he confirmed that he had re-visited the entire Appellant's medical file, including the [Hospital #1] record and information received from [Appellant's Cardiologist #1] and he stated:

> I have reviewed the recently submitted medical information. In my opinion, the only factor which might indicate the claimant had a probable cardiac anomaly secondary to the collision in question would be the documentation of his CK-MB enzyme levels on April 22, 1998. On the day of admission to hospital, the claimant's CK-MB percent was at 2%. Normal is less than 2%. This would be the only possible marker of a cardiac anomaly. Given the remainder of documentation in the claimant's file, it is my opinion that the CK-MB percent at the upper limit of normal, was not indicative of a probable myocardial infarction at that time. The motor vehicle collision would not have been responsible for the claimant's coronary artery disease, which was subsequently identified.

[MPIC's Doctor] concluded his report by indicating:

> The information submitted from the [Hospital #1] file does not establish a probable cause-effect relationship between [the Appellant's] cardiac condition, and the collision in question, in my opinion. (underlining added)

The Internal Review Officer in his decision noted that the Appellant had bypass surgery on March 19, 2001. The Internal Review Officer indicated that this information was again resubmitted to [MPIC's Doctor] and indicated the following in his interdepartmental memorandum dated April 18, 2002:

> I reviewed this information. The information does not change my opinion regarding the cause/effect nature between this patient's cardiac problems and his motor vehicle collision/mishap in question. (underlining added)

The Internal Review Officer, relying on the medical opinions of [Appellant's Cardiologist #1] and [MPIC's Doctor], dismissed the Appellant's application for review and confirmed the case manager's decision.

The Appellant filed a Notice of Appeal dated May 22, 2003.

Subsequent to the filing of the Notice of Appeal, MPIC requested a report from [Appellant's Cardiologist #2]. [Appellant's Cardiologist #2] in his report concluded that there was no causal connection between the motor vehicle accident and the Appellant's atherosclerosis/myocardial infarction. [Appellant's Cardiologist #2] in his report indicated there were two questions he was required to answer:

1. Did the motor vehicle accident cause the atherosclerosis subsequently discovered in [the Appellant] (sic)?
2. Did the motor vehicle accident cause the myocardial infarction (i.e. heart damage) that was discovered later?

> I will try and summarize the history as I have understood it from the material that you provided to me. The patient suffered a motor vehicle accident on April 21, 1998. The patient was hit by a car when he was crossing the road. He sustained multiple soft tissue and boney injuries and a head injury. The injuries relevant to the questions above include fractures of his rib on the right side, 6th, 7th and 8th ribs on the left side posteriorly, the 5th rib on the left side anteriorly. An Electrocardiogram taken in the Emergency Room at [Hospital #2] where he had been taken originally did not show any evidence of an infarction. The tracing had mild T wave abnormalities. No subsequent electrocardiographical tracings were done during his hospitalization. The patient was transferred to [Hospital #1] where he was treated with analgesics and Physiotherapy. He was discharged on May 1, 1998.
>
> Biochemical markers of cardiac injury were drawn on one occasion at the [Hospital #2]. The Creatinine Kinase which is an enzyme released with muscle injury was elevated at 471 units. This is a modest elevation. The MB fraction which is specific to heart muscle was normal. This test was done in the Emergency Room at [Hospital #2]. A second sample drawn at [Hospital #1] on April 22nd showed that the total CK was 483 with a CKMB of 10 which is slightly elevated but the percentage ratio is borderline. The result

> is called "grey zone" where it is indeterminate whether there has been myocardial (heart) injury or not. His total Creatinine Kinase was done on April 23rd and was 411 units. This was less than the preceding days and no other samples were drawn. They did not test the MB fraction on that sample. Subsequently the patient attended [Appellant's Cardiologist #1] in June 1998. An Electrocardiogram done there on June 22nd, 1998 was abnormal suggesting heart injury to the front of the heart. However an Echocardiogram done July 2, 1998 which did not show any evidence of heart damage. A subsequent MIBI Test done in March of 2000 showed reversible lack of blood supply to the front of the heart. There was no evidence of myocardial (heart muscle) damage seen on that test. A Coronary Angiogram carried out in May 2000 showed the artery on the front of his heart called the left anterior descending (LAD) was completely (100%) occluded at its origin. There was additional atherosclerotic disease in his right and circumflex coronary arteries. Of significance is the fact that Ventriculogram which demonstrates the heart pumping function showed damage to the front and tip of the heart muscle not seen on any previous tests.
>
> A myocardial infarction (damage to the heart muscle) is due to complete blockage of a coronary artery can occur as a result of blunt trauma. In fact the artery most commonly involved is the left anterior descending artery. Because of its position anteriorly it is most vulnerable to damage.
>
> In the evidence cited above the patient did not have a myocardial infarction, (damage to his heart muscle) from the motor vehicle accident. The evidence for that is the normal Echocardiogram done on July 2, 1998. From the investigations available it appears that the permanent damage to his heart occurred sometime between March of 2000 and May of 2000.
>
> The patient's atherosclerosis was not produced by the motor vehicle accident. His major risk factor for the coronary artery disease (atherosclerosis) was his smoking.
>
> In summary, I could state with reasonable certainty, that the patient did not have a myocardial infarction at the time of the motor vehicle accident. His atherosclerosis was not due to the motor vehicle accident. One can only speculate whether the stress of the accident subsequently accelerated the atherosclerotic process that was probably already present at the time of the accident. (underlining added)

[Appellant's Cardiologist #2] disagreed with [Appellant's Cardiologist #1's] diagnosis that commotio cordis was relevant to the Appellant's medical condition.

On December 18, 2006 the Commission wrote to [Appellant's Cardiologist #3], a prominent cardiac surgeon who had been [text deleted] at [text deleted] between 1995 and 2000.

[Appellant's Cardiologist #3] subsequently moved to Minnesota and was the Director of Cardiac Surgery at [text deleted] in [text deleted], Minnesota and as well had cardiac surgical privileges in a number of hospitals both in [text deleted] and in [text deleted].

[Appellant's Cardiologist #3] was provided with the relevant medical reports in respect of the Appellant and was asked a number of questions which he responded to in a letter to the Commission dated October 30, 2007. [Appellant's Cardiologist #3] said:

> There are three irrefutable facts:
>
> 1. The force of the accident of a car hitting a pedestrian is very significant.
> 2. [The Appellant] sustained significant and permanent injuries.
> 3. [The Appellant] received inadequate evaluation on his admission to the Trauma Service at the [Hospital #1]. Initial multi-organ evaluation of chest, heart, lung, aorta, and great vessels was not carried out.
>
> Based on the data provided and the force of the accident, I can conclude that [the Appellant] did not have an adequate initial evaluation. Furthermore, appropriate tests, outlined below, were not done or were partially done weeks or months later:
>
> - CT of chest and great vessels
> - Cardiac echo
> - Serial cardiac enzymes
> - Follow-up cardiac echo to rule out delayed cardiac injury or pericardial effusion
> - No cardiology consult was obtained which was indicated by force of injury to the chest.
>
> The delay in finally getting cardiology evaluation was excessively long.
>
> e.g. The Appellant was referred to [Appellant's Cardiologist #1] for the purpose of having his heart condition evaluated in July of 1998 fully two months after the motor vehicle accident.
>
> To [Appellant's Cardiologist #1's] credit appropriate testing
> - Cardiac echo
> - Profusion scan
> - Coronary angiogram
> - But NO CT of chest
>
> were finally done months to years after the accident.

In his letter [Appellant's Cardiologist #3] stated:

> Left anterior descending – This artery is closest to the front of the patient. The artery may be injured by force dislodging a plaque. This is very uncommon – This was not evaluated at the initial hospitalization and although not likely, there is a reasonable possibility this could have been damaged.
>
> Occlusion of the left anterior descending could cause congestive heart failure. (underlining added)
>
> Inducible Ischemia – This is usually identified by specific viability profusion scans when the patient is exercised on treadmill or chemically induced stress with or without cardiac echo. The fundamental problem is that an adequate cardiac evaluation at initial hospitalization was not done. Nevertheless, elevated enzymes and edema can be a result of this injury.
>
> Inducible ischemia can occur with muscle contusion or tear of myocardium. This could result from a severe force of accident to the chest.
>
> The symptoms [the Appellant] reported to his family MD could partly be caused by the vehicle accident – but again he was never evaluated until seen by [Appellant's Cardiologist #1].
>
> Contributing Factors
> a. Stress, trauma and persistent undiagnosed injuries in a timely manner are always significant.
> b. Decreased conditioning and no cardiac and physical rehab therapy is significant.
> c. Weight gain, deconditioning and neuropsychotic drugs are a negative as you would expect.

The Commission in its letter to [Appellant's Cardiologist #3] dated December 18, 2006 had asked [Appellant's Cardiologist #3] a number of questions including the following:

> 5. During his initial hospitalization at the [Hospital #1] immediately after the incident, and prior to his discharge, did [the Appellant] have a probable cardiac condition?
> 6. If he did have a probable cardiac condition at that time, what was the nature of that condition?
> 7. Did [the Appellant] sustain a myocardial infarction as a result of the collision in question?
> 8. On a balance of probabilities, did [the Appellant's] chest trauma in April 1998 cause or contribute in a material way to his subsequent cardiac problems and to his need for coronary artery bypass surgery in March 2001? If so, how?

In response to these questions [Appellant's Cardiologist #3] stated:

> There would be no way to know if [the Appellant] (sic) had a probable cardiac condition at initial hospitalization as he was never properly evaluated, therefore all related questions numbers 5. through 8. cannot be answered as he was never evaluated. (underlining added)

[Appellant's Cardiologist #3] commented on the medical opinions of [Appellant's Cardiologist #2] and [Appellant's Cardiologist #1] as follows:

> [Appellant's Cardiologist #2] – Cardiologist
>
> [Appellant's Cardiologist #2] is an excellent cardiologist who provided a good overview with valid information. However, with no adequate investigation initially at the [Hospital #1], there is more than reasonable doubt [the Appellant] received very significant multi-organ injury.
>
> [Appellant's Cardiologist #1] – Cardiologist
>
> Was the only doctor who raised the possibility of cardio-thoracic injury but regrettably his evaluations were months to years later.

[MPIC's Doctor] was requested by MPIC to respond to the responses made by [Appellant's Cardiologist #3] to the questions submitted to [Appellant's Cardiologist #3] by the Commission. In an interdepartmental memorandum dated November 16, 2000 [MPIC's Doctor] acknowledged that he was not a cardiologist. He indicated that he agreed with [Appellant's Cardiologist #3] that a probable cause/effect relationship cannot be determined between the motor vehicle accident injuries and the Appellant's cardiac condition given the evidence at hand. [MPIC's Doctor] stated:

> In conclusion, I think [Appellant's Cardiologist #3's] report outlines the numerous deficiencies in the evidence at hand which prevent a probable cause/effect relationship being established between the collision in question, and [the Appellant's] current cardiac difficulties. (underlining added)

The Claimant Adviser Office requested [Appellant's Cardiologist #3] to respond to [MPIC's Doctor's] interdepartmental memorandum dated November 16, 2007. In a letter dated March 7, 2008 [Appellant's Cardiologist #3] stated:

> [MPIC's Doctor] states, to quote, "the critical question is whether the left anterior descending artery was occluded as a probable consequence of the motor vehicle." He then in the second paragraph concludes by giving his interpretation of my letter. I believe he came to the wrong conclusion to what I said.
>
> I said, *it was possible*, regretfully, it was clear he received some cardiac contusion by the force of the accident with initial rise of cardiac enzymes and multiple rib fractures. This was combined with multi organ injury including brain hemorrhage. However, initial inadequate evaluation does not allow [MPIC's Doctor] the liberty to conclude it was not probable.
>
> I believe, [the Appellant] (sic) is due compensation for this unfortunate severe injury, none of which he was responsible for. By the default of his inadequate evaluation and treatment, the conclusion should remain as I stated in my review, "it is possible".
>
> However, cause and effect cannot be proved because of the long time interval of events. The just and clear decision should have been in favor of [the Appellant] (sic). The foundation of the claim should be about the whole patient and his clinical course…

[Appellant's Cardiologist #3] concludes his letter by stating that the health services in Manitoba mismanaged, delayed and inadequately cared for the Appellant over several years and regretfully failed the Appellant and as such, he was entitled to receive compensation.

Appeal Hearing

The relevant provisions of the MPIC Act and Regulations in respect of this appeal are Section 136(1) of the Act and Section 5(a) of Manitoba Regulation 49/94 which state:

> **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;
>
> (b) the purchase of prostheses or orthopedic devices;

(c) cleaning, repairing or replacing clothing that the victim was wearing at the time of the accident and that was damaged;

(d) such other expenses as may be prescribed by regulation.

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 is prescribed by a physician;

The appeal hearing took place on November 25 and 26, 2008 in [Manitoba]. The Appellant was represented by Robert Sample of the Claimant Adviser Office and MPIC was represented by Ms Dianne Pemkowski.

[Appellant's Cardiologist #3] testified at the hearing and essentially confirmed his statement set out in his reports dated October 30, 2007 and March 7, 2008. In his testimony [Appellant's Cardiologist #3] emphasized that the Appellant's left anterior descending (LAD) artery, which is closest to the front of the Appellant, may have been injured by the force of the collision, causing the plaque to dislodge. He further testified that as a result collusion of the LAD artery could have caused congestive heart failure. Unfortunately because there was not a proper cardiac evaluation, that was not done at the hospital to determine whether this in fact had occurred. [Appellant's Cardiologist #3] also testified that the elevated enzymes exhibited by the Appellant could also have resulted from the injury the Appellant sustained in the motor vehicle accident and this may have caused the Appellant's heart problems. Unfortunately since the Appellant did not receive an adequate cardiac evaluation in his initial hospitalization, there is no way to determine if the Appellant had a probable cardiac condition in the initial hospitalization.

[Appellant's Cardiologist #3] also testified the Appellant:

1. Prior to the motor vehicle accident regularly exercised by walking great distances daily and never complained prior to the motor vehicle accident of having any chest pain.
2. The only risk factor associated with the development of cardiac problems was that the Appellant smoked a pipe.
3. The Appellant's chest pains following the motor vehicle accident were never properly evaluated until several years later by [Appellant's Cardiologist #1], and as a result, the Appellant had bypass surgery on March 19, 2001.

[Appellant's Cardiologist #3] also testified that:

1. Due to the significant injuries received by the Appellant in the motor vehicle accident, including brain injury and four fractured ribs, that the stress associated with the motor vehicle accident would be a significant factor in the development of the Appellant's cardiac problems.
2. After the motor vehicle accident the Appellant was unable to continue his exercise program.
3. Due to the brain hemorrhage caused by the motor vehicle accident the Appellant was unable to properly evaluate himself and obtain appropriate medical assistance after the motor vehicle accident.
4. The inadequate evaluation at the [Hospital #1] subsequent to the motor vehicle accident did not allow for a conclusion to be made that the LAD artery was not occluded as a result of the motor vehicle accident.
5. It would be just as probable that the motor vehicle accident caused the Appellant's heart problems as it is to conclude that it was not probable.

[Appellant's Cardiologist #3] also testified that:

1. The significant trauma the Appellant suffered as a result of the motor vehicle accident, which included four fractured ribs, constant pain to his chest and brain injury, caused the Appellant significant stress, depression and anxiety.
2. This had an adverse effect on the Appellant's quality of life.
3. The Appellant was physically unable to function at a level he had functioned at prior to the motor vehicle accident. He was unable to continue walking three and a half hours to four hours per day. As a result he had become extremely deconditioned.
4. Having regard to the above-mentioned factors, it was likely that the motor vehicle accident caused the Appellant's heart problems. Because of the failure to properly evaluate him at the time of his initial hospitalization, one could not conclude that there was a probable relationship between the Appellant's cardiac condition and the motor vehicle accident.

[Appellant's Cardiologist #3] further testified that:

1. The Appellant was an innocent victim who suffered an unfortunate severe injury which had a traumatic effect on his life.
2. The lack of adequate evaluation and treatment at the time of the motor vehicle accident prejudice the Appellant's claim for compensation, having regard to the following factors:
    (a) The Appellant's healthy condition prior to the motor vehicle accident.
    (b) The only risk factor was that he smoked a pipe.
    (c) The force of the accident and the significant injuries the Appellant received as a result thereof.

[Appellant's Cardiologist #3] concluded that:

1. The June 22, 1998 echo (EKG) indicated it was just as probable to assert that the motor vehicle accident caused or materially contributed to the Appellant's cardiac problems as it is to assert that there was no probable cause between the motor vehicle accident and the Appellant's heart problems.
2. Fairness required that there be a finding that the motor vehicle accident did cause the occlusion to the Appellant's LAD artery which resulted in the heart surgery.

The Appellant testified at the hearing and described the motor vehicle accident he was involved in on April 21, 1998 which caused significant injuries including multiple bruising, fractured ribs, left ankle strain, bruising to abdominal and chest areas and a brain injury as well as disfigurement affecting elbows, right hand, lower limbs, neck and face. He testified that:

1. Before the motor vehicle accident he was in good condition, walked approximately three and a half to four hours each day.
2. He had never had any chest pain prior to the motor vehicle accident.
3. He acknowledged that he had smoked a pipe for a number of years but did not inhale the smoke from the pipe.
4. Subsequent to the motor vehicle accident he started to suffer from severe pains to his chest, which continued after the healing of his rib fractures.
5. As a result of the injuries to his head from the motor vehicle accident he had significant problems in respect to his memory and concentration, and his ability to read several books a week was severely diminished.
6. As a result the effects of the motor vehicle accident had a traumatic effect on his quality of life.

7. He was physically unable to function at the level that he did prior to the motor vehicle accident and was unable to continue walking between three and a half to four hours per day and that resulted in him becoming extremely deconditioned.

[Appellant's Cardiologist #2], at the request of MPIC, reviewed the relevant medical reports relating to the Appellant and submitted a report to MPIC dated October 25, 2004. [Appellant's Cardiologist #2] concluded that the motor vehicle accident did not cause the atherosclerosis subsequently discovered in the Appellant and that the motor vehicle accident did not cause the myocardial infarction (i.e. heart damage) that was discovered subsequent to the motor vehicle accident.

[Appellant's Cardiologist #2] testified at the hearing by teleconference. In his testimony [Appellant's Cardiologist #2] confirmed comments he made in his report to MPIC dated October 25, 2004. He testified that:

1. After the motor vehicle accident on April 21, 1998 an electrocardiogram taken in the emergency room at [Hospital #2] did not show any evidence of a myocardial infarction but the tracing had mild T wave abnormalities.
2. The biochemical sample drawn at the [Hospital #1] on April 22, 1998 showed CK had 483 units and CK-MB of 10 – which was slightly elevated but the percentage ratio is borderline.
3. These results were a "grey zone" and were indeterminate as to whether or not there had been any heart injury to the Appellant as a result of the motor vehicle accident.
4. A biochemical sample drawn on April 23, 1998 was 411 units which was less than the preceding sample on April 22, 1998 and no other samples were drawn.

5. These tests did not disclose any evidence which would establish the Appellant suffered from a heart injury as a result of the motor vehicle accident on April 21, 1998.

[Appellant's Cardiologist #2] further testified that:

1. In an Echocardiogram done on the Appellant on July 2, 1998 did not show any evidence of heart damage
2. A MIBI Test done in March of 2000 showed reversible lack of blood supply to the front of the heart but did not disclose any evidence of the Appellant suffering from heart damage.

[Appellant's Cardiologist #2] further testified that:

1. A Coronary Angiogram carried out in May of 2000 showed that the artery on the front of his heart called the left anterior descending (LAD) was completely (100%) occluded at its origin.
2. The angiogram further disclosed that there was also additional atherosclerotic disease in his right and circumflex coronary arteries.
3. It was significant that there was not only 100% occlusion to the Appellant's left anterior artery but that coronary disease had developed in the Appellant's two other arteries.
4. In addition to the coronary disease in the left anterior descending artery, the existence of coronary disease in these two arteries not being disclosed on any previous medical tests that were conducted on the Appellant demonstrated that the Appellant's coronary disease was not caused by the motor vehicle accident.

[Appellant's Cardiologist #2] in his testimony stated that:

1. Damage to the heart muscle due to a complete blockage of the coronary artery could result from trauma.
2. The evidence, however, did not disclose that as a result of the motor vehicle accident the Appellant had damage to his heart muscle.
3. The evidence did disclose that the permanent damage to the Appellant's heart occurred sometime between March of 2000 after the MIBI test had been performed and May of 2000 when a coronary angiogram disclosed that the Appellant's left artery was completely blocked.

[Appellant's Cardiologist #2] testified that for these reasons he could state with reasonable certainty that:

1. The Appellant did not have a myocardial infarction at the time of the motor vehicle accident.
2. The Appellant's atherosclerosis was not due to the motor vehicle accident.

Submissions:

The Commission accepts the submission of the Claimant Adviser that as a result of the motor vehicle accident the Appellant suffered significant physical injuries and cognitive difficulties which had a traumatic effect on the Appellant's life. Prior to the motor vehicle accident he was a healthy individual who never complained of chest pain and never saw a doctor in respect of cardiac problems. As a result of the motor vehicle accident the Appellant suffered blunt trauma to his chest which resulted in four fractured ribs and massive bruising to his abdominal/chest area as well as a brain injury. The Appellant testified that subsequent to the motor vehicle accident he suffered from chest pains, from anxiety and stress, memory loss and lack of

concentration, which severely affected his quality of life. He was unable to continue the walk between three and a half and four hours and to read newspapers, magazines and periodicals.

The Claimant Adviser Office submitted that [Appellant's Cardiologist #3] had reviewed the medical documentation with respect to the Appellant and was appalled by the failure of [Hospital #1] to carry out an adequate initial evaluation to determine whether or not the blunt trauma the Appellant received to his chest as a result of the motor vehicle accident could have caused his heart damage. The Claimant Adviser Office submitted that because the medical attention was initially focused on the Appellant's obvious injuries with respect to the four fractured ribs, the concussion, the brain injuries and the areas of massive scrapes and bruising to his body, that the [Hospital #1] medical staff did not pay any attention to conducting a proper examination as to whether or not, as a result of the trauma to the Appellant's chest, he suffered damage to the heart. The Claimant Adviser submitted that if a proper examination had been carried out immediately following the motor vehicle accident it probably would have demonstrated that the Appellant suffered damage to his heart. The Claimant Adviser submitted that the Commission should accept [Appellant's Cardiologist #3's] testimony:

1. Having regard to the Appellant's good health prior to the motor vehicle accident.
2. He had not complained of any heart problems prior to the motor vehicle accident.
3. The only risk factor was that the Appellant smoked a pipe.
4. It was just as probable there was a causal connection between the motor vehicle accident and the Appellant's heart condition as it was that it wasn't probable.

The Claimant Adviser further indicated that:

1. [Appellant's Cardiologist #3] and [Appellant's Cardiologist #2] both agreed that it would be normal for the Appellant, having regard to his age, to have suffered some pre-existing atherosclerotic plaque in his arteries at the time of the motor vehicle accident.
2. Both [Appellant's Cardiologist #2] and [Appellant's Cardiologist #3] agreed that severe blunt force trauma to the Appellant's chest could have caused a fissuring of the underlying pre-existing atherosclerotic plaque.
3. The Commission should accept [Appellant's Cardiologist #3's] opinion that the formation of blood clots and inflammation cycle could have been activated by the trauma, all of which would have led to the development of cardiac symptoms experienced by the Appellant in the occlusion of the LAD artery.
4. The Appellant prior to the motor vehicle accident was a retired, relaxed senior citizen who enjoyed walking miles each day, enjoyed reading, and took pleasure in socializing with his friends.
5. However, as a result of the injuries the Appellant sustained in the motor vehicle accident, combined with the stress, anxiety and depression arising due to these injuries, it would have been unlikely the Appellant would have experienced the debilitating cardiac problems he had suffered but for the motor vehicle accident.

The Claimant Adviser concluded that the motor vehicle accident injuries the Appellant suffered, together with his stress, anxiety and depression, caused or materially contributed to the development of the Appellant's myocardial infarction. The Claimant Adviser therefore submitted that the Appellant had established on a balance of probabilities that there was a causal connection between the motor vehicle accident and the Appellant's myocardial infarction.

MPIC legal counsel asserted that the onus is on the Appellant to establish on a balance of probabilities that there was a causal connection between the motor vehicle accident and the Appellant's heart damage that resulted in the cardiac surgery. MPIC's legal counsel submitted having regard to the medical opinions of [Appellant's Cardiologist #1], [MPIC's Doctor] and [Appellant's Cardiologist #2] the Appellant has failed to establish on a balance of probabilities that there is a causal connection between the motor vehicle accident and the Appellant's heart damage.

MPIC's legal counsel reviewed the medical reports of [Appellant's Cardiologist #1], who had initially evaluated the Appellant two months after the motor vehicle accident and subsequently conducted further tests in May of 2000, and concluded that there was no causal connection between the Appellant's motor vehicle accident and his heart injury.

MPIC's legal counsel also referred to reports of [MPIC's Doctor], who also concluded that there was no causal connection between the Appellant's coronary artery disease and the motor vehicle accident.

MPIC's legal counsel also referred to the medical reports and testimony of [Appellant's Cardiologist #2], who concluded that there was no connection between the motor vehicle accident causing the Appellant's atherosclerosis or his myocardial infarction. MPIC's legal counsel reviewed [Appellant's Cardiologist #2's] medical reports and his testimony and emphasized [Appellant's Cardiologist #2's] testimony that the existence of atherosclerotic disease to the Appellant's right circumflex coronary arteries had not been seen in previous tests, and indicated that the Appellant's atherosclerosis in these arteries had not been produced by the motor vehicle accident. MPIC's legal counsel emphasized [Appellant's Cardiologist #2's]

testimony that the Appellant had smoked a pipe over a long period of time and this was a major risk factor for the Appellant's coronary disease. MPIC's legal counsel therefore urged the Commission that the Appellant's appeal should be dismissed and the Internal Review Officer's decision dated September 25, 2002 be confirmed.

Decision

The Commission finds that the Appellant has failed to establish on a balance of probabilities that there was a causal connection between the motor vehicle accident and the Appellant's heart damage that resulted in the cardiac surgery. The Commission acknowledges that the Appellant's cardiac problems had a traumatic effect on the Appellant's quality of life but finds that this evidence does not establish on a balance of probabilities that the Appellant's myocardial infarction was solely caused or materially contributed to the Appellant's heart problems.

[Appellant's Cardiologist #3] was a very impressive witness in support of the Appellant's position. [Appellant's Cardiologist #3] was appalled by the failure of the [Hospital #1] to conduct the appropriate evaluation at the time of the motor vehicle accident. He was of the firm opinion that had an appropriate medical evaluation occurred, a causal connection between the Appellant's heart problems and the motor vehicle accident would have been established. He submitted that because there was no evaluation of the Appellant's heart condition at the time of the motor vehicle accident, it was just as probable as it was not probable that there was a causal connection between the Appellant's heart condition and the motor vehicle accident.

The Commission notes that [Appellant's Cardiologist #3] therefore concluded that:

1. Having regard to the Appellant's condition prior to the motor vehicle accident that the traumatic effects the Appellant suffered from the motor vehicle accident physically,

emotionally and mentally, caused or materially contributed to the Appellant suffering a myocardial infarction.

2. In all fairness, justice demanded that MPIC should recognize that the motor vehicle accident caused or materially contributed to the Appellant's myocardial infarction.

[Appellant's Cardiologist #3] is unable to state that there was a probable connection between the motor vehicle accident and the Appellant's myocardial infarction. However [Appellant's Cardiologist #1], [MPIC's Doctor], and [Appellant's Cardiologist #2], all concluded there was not a probable causal connection between the Appellant's motor vehicle accident and the myocardial infarction which resulted in the Appellant having major surgery.

The Commission notes that [Appellant's Cardiologist #1] did see the Appellant on several occasions and found no connection between the motor vehicle accident and the Appellant's heart problems. In an assessment dated July 17, 2000 [Appellant's Cardiologist #1] concluded:

> The temporal sequence of events in [the Appellant's] case, appears to indicate that he originally had MUGA scanning and echocardiography which failed to reveal left ventricular dysfunction. He subsequently manifested evidence of left ventricular dysfunction after being seen in 1998. This seems to indicate that there was a progressive decline in his cardiac status in the two years between 1998, and the present.
>
> At this time, in my opinion, there is not a medically probable causal relationship between the collision in question, and [the Appellant's] cardiac condition. He does not have evidence of commotio cordis, on the balance of probability. He appears to have evidence of proximal left anterior descending coronary artery occlusive disease with significant left ventricular dysfunction. There is not a medically probable causal relationship between this condition, and the trauma in question. (underlining added)

In his report to MPIC dated June 23, 2000 he indicated:

> Based on available (or in fact lack of) data, one cannot conclude with absolute certainty what is the relation between this patient's apparent myocardial infarction and MVA. While searching the literature I found a commotio cordis which is most common in athletes during competitive sport, may present as myocardial infarction (and sudden

> death) sometime after the accident. Whether this is the case here it is not possible to say, but I am not in any position to rule out this in absolute certainty. (underlining added)

[MPIC's Doctor] was asked on several occasions to review the Appellant's medical file and on December 29, 2000 he provided an interdepartmental memorandum to the case manager in which he stated:

> I have reviewed the recently submitted medical information. In my opinion, the only factor which might indicate the claimant had a probable cardiac anomaly secondary to the collision in question would be the documentation of his CK-MB enzyme levels on April 22, 1998. On the day of admission to hospital, the claimant's CK-MB percent was 2%. Normal is less than 2%. This would be the only possible marker of a cardiac anomaly. Given the remainder of documentation in the claimant's file, it is my opinion that the CK-MB percent at the upper limit of normal, was not indicative of a probable myocardial infarction at that time. <u>The motor vehicle collision would not have been responsible for the claimant's coronary artery disease, which was subsequently identified</u>. (underlining added)

[Appellant's Cardiologist #2] did review the medical reports and concluded that there was no evidence that there was a causal connection between the Appellant's myocardial infarction and the motor vehicle accident. [Appellant's Cardiologist #2] determined that the echocardiogram that was performed on July 2, 1998 indicated no evidence of any myocardial infarction. He further determined that the permanent damage to the heart occurred (after the motor vehicle accident on April 21, 1998) between March of 2000 when a MIBI test was done and showed no evidence of heart muscle damage, and May of 2000 when a coronary angiogram showed a 100% occlusion of the LAD artery and additional atherosclerotic disease to the Appellant's right and circumflex coronary arteries.

[Appellant's Cardiologist #2] testified the existence of the atherosclerotic disease to his right and circumflex coronary arteries was not seen in any previous tests until the month of May, 2000 and this indicated to him that the Appellant's atherosclerosis was not produced by the motor vehicle accident. He further testified that the major risk factor for the Appellant's coronary artery

disease was his smoking. As a result [Appellant's Cardiologist #2] concluded with reasonable certainty that the Appellant did not have a myocardial infarction at the time of the motor vehicle accident and that his atherosclerosis was not due to the motor vehicle accident.

[Appellant's Cardiologist #3] in his letter of October 30, 2007 stated:

> [Appellant's Cardiologist #2] is an excellent cardiologist who provided a good overview with valid information. However, with no adequate investigation initially at [Hospital #1], there is more than reasonable doubt [the Appellant] received very significant multi-organ injury.

The Commission finds that [Appellant's Cardiologist #3] was not able to confirm that there was a probable causal connection between the Appellant's motor vehicle accident and the damage to his heart. At best [Appellant's Cardiologist #3] stated that there was a possible connection between the Appellant's heart problems and the motor vehicle accident. The Commission finds that [Appellant's Cardiologist #3's] reports and his testimony do not corroborate the Appellant's testimony that there was a causal connection between the motor vehicle accident and his heart problems. The Commission also finds that [Appellant's Cardiologist #1] personally examined the Appellant on several occasions, and [MPIC's Doctor] and [Appellant's Cardiologist #2] reviewed all of the relevant medical opinions, and all concluded that there was no causal connection between the motor vehicle accident and the Appellant's myocardial infarction. [Appellant's Cardiologist #2] specifically found that the Appellant's atherosclerosis was not due to the motor vehicle accident. For these reasons the Commission gives greater weight to the medical opinions of [Appellant's Cardiologist #1], [MPIC's Doctor] and [Appellant's Cardiologist #2] than it does to the medical opinion of [Appellant's Cardiologist #3].

As a result, the Commission finds that the Appellant failed to establish on a balance of probabilities that there was a causal connection between his myocardial infarction and the motor vehicle accident and that the Appellant's atherosclerosis was not due to the motor vehicle accident. The Commission therefore confirms the decision of the Internal Review Officer dated January 30, 2003 and dismisses the Appellant's appeal.

Dated at Winnipeg this 17th day of December, 2008.

MEL MYERS, Q.C.

PAUL JOHNSTON

LES MARKS