Manitoba

# Automobile Injury Compensation Appeal Commission

**IN THE MATTER OF an Appeal by [APPELLANT]**
**AICAC File No.: AC-12-195**

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| **PANEL:** | **Ms. Jacqueline Freedman, Chair**<br>**Ms. Laura Diamond**<br>**Ms. Linda Newton** |
| **APPEARANCES:** | **The Appellant, [text deleted], was represented by Mr. Sean Young of the Claimant Adviser Office; Manitoba Public Insurance Corporation ("MPIC") was represented by Mr. Trevor Brown.** |
| **HEARING DATE(S):** | **October 1 and 2, 2020.** |
| **ISSUE(S):** | **Whether the Appellant is entitled to further permanent impairment benefits.** |
| **RELEVANT SECTIONS:** | **Section 126 and subsections 127(1), 129(2), and 184(1) of The Manitoba Public Insurance Corporation Act ("MPIC Act") and section 1 of, and Schedule A to, Manitoba Regulation 41/94.** |

**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

**Background:**

[text deleted] (the "Appellant") was the driver of a vehicle when she was involved in accidents on four separate occasions:

1. December 26, 1997 (the "First MVA");
2. July 10, 2000 (the "Second MVA");
3. March 23, 2002 (the "Third MVA"); and
4. September 13, 2002 (the "Fourth MVA").

All of the accidents may collectively be referred to as the "MVAs".

The Appellant suffered various injuries as a result of the MVAs and she received certain treatments pursuant to the Personal Injury Protection Plan ("PIPP") provisions of the MPIC Act.

MPIC reviewed the Appellant's injuries, in order to review her entitlement to permanent impairment ("PI") benefits. The case manager issued a decision letter dated October 2, 2012, which provided a total PI benefit to the Appellant of 6%, in respect of alteration of intervertebral discs T11-12 (3%) and L5-S1 (3%), arising from the Fourth MVA.

The Appellant disagreed with the decision of the case manager, being of the view that she was entitled to further PI benefits, and filed an Application for Review. The Internal Review Officer considered the decision of the case manager and issued an Internal Review decision dated January 14, 2013, which provides as follows:

> […] Your medical evidence has been reviewed numerous times by a number of medical professionals. There is no new medical evidence that would make me question the validity of the consultant's recent review regarding your Permanent Impairment entitlement. As such, it is my opinion that the Permanent Impairment calculation outlined in the October 2, 2012 decision is correct based upon the available medical information and therefore, I am confirming the decision and dismissing your Application for Review.

The Appellant disagreed with the decision of the Internal Review Officer and filed this appeal with the Commission.

**Issue:**

The issue which requires determination on this appeal is whether the Appellant is entitled to further PI benefits.

**Decision:**

For the reasons set out below, the panel finds that the Appellant has met the onus to establish, on a balance of probabilities, that she is entitled to a PI benefit in respect of her osteitis pubis, but she has failed to establish, on a balance of probabilities, an entitlement to any other PI benefits.

**Preliminary and Procedural Matters:**

This hearing took place during the COVID-19 pandemic. The Appellant appeared at the hearing by videoconference with the consent of the panel and of counsel. The panel and counsel attended in person.

The panel reviewed the issue under appeal, and confirmed that the 23 further PI benefits that the Appellant is seeking (21 separate impairments together with 2 enhancements) had been identified in a document submitted by counsel for the Appellant, which is attached to these Reasons as Appendix 1. In Appendix 1, the Appellant identified each PI benefit that she is seeking, the specific MVA to which it relates, and the section of the MPIC Act and regulation upon which she relies. Subsequent to providing Appendix 1, counsel for the Appellant provided a further letter, noting that the PI for bladder irritability relates to the Fourth MVA, rather than the Second MVA.

**Opening Statements:**

After concluding discussions of the preliminary matters, the parties were then invited to give opening statements. Counsel for both parties very briefly stated their positions, which will not be summarized here, as their positions were reflected in their submissions, below.

**Legislation:**

The relevant provisions of the MPIC Act are as follows:

> **Meaning of "permanent impairment"**
>
> 126 In this Division, "permanent impairment" includes a permanent anatomicophysiological deficit and a permanent disfigurement.
>
> **Lump sum indemnity for permanent impairment**
>
> 127(1) Subject to this Division and the regulations, a victim who suffers permanent physical or mental impairment because of an accident is entitled to a lump sum indemnity of not less than $500. and not more than $100,000. for the permanent impairment.
>
> **Impairment not listed on schedule**
>
> 129(2) The corporation shall determine a percentage for any permanent impairment that is not listed in the prescribed schedule, using the schedule as a guideline.
>
> **Powers of commission on appeal**
>
> 184(1) After conducting a hearing, the commission may
> (a) confirm, vary or rescind the review decision of the corporation; or
> (b) make any decision that the corporation could have made.

Manitoba Regulation 41/94 (the "PI Regulation") provides, in part, as follows:

> **Compensation for permanent impairment based on Schedule**
>
> 1 Compensation for permanent impairments shall be determined on the basis of Schedule A.

The PI Regulation has been amended from time to time. When considering the Appellant's claim for PI benefits, the applicable version of the PI Regulation is the version which was in force at the time that the particular MVA occurred. The original version of the PI Regulation, which took effect

March 1, 1994, is applicable to the First MVA, and any PI benefit claims arising from that MVA. The amending regulation 41/2000 to the PI Regulation, which came into force on April 15, 2000, is applicable to the Second, Third, and Fourth MVAs and any PI benefit claims arising from those MVAs. In these Reasons, and in Appendix 1, a reference to a particular provision of the PI Regulation, or to Schedule A thereto, should be read as referring to the applicable PI Regulation, as just described.

**Evidence for the Appellant:**

The Appellant described the MVAs, the injuries that she suffered and the nature of the treatments that she received. She said that the First MVA was a high-speed impact where the other vehicle went through a red light and her car struck it with the driver's side corner. She felt pain on the left side, in her hip, back and sacroiliac joint, which got worse as time progressed. She saw [Doctor 3] and had physiotherapy treatment. She also saw [Doctor 1] and went to [Doctor 2] for athletic therapy treatment, and also went for some massage therapy. She was told that stretching was very important, and she was also given strengthening exercises to do. She was challenged, and was feeling pain, but she was told that "pain is your friend".

The Appellant said that she got some benefit from treatment, but in the big picture, her function now is nowhere near what it used to be before the MVAs. She has a constant imbalance throughout her pelvis, and her hip flexors are extremely tight. She said she was progressively losing function and strength, with increasing pain and limitation. She was required to continue working in order to be able to afford therapy. Although there were accommodations made for her at work, such as ensuring that the floor was level and changes to her computer monitor, she must still be incredibly mindful to ensure that she doesn't overexert herself.

With respect to her cervical spine, the Appellant said she that could not lie on her sides, and she still can't tolerate anything touching the back of her neck. Mild stretching does now help her neck somewhat; back then, heat and ice helped. With respect to her lumbar spine, her left side took the brunt of the force of the First MVA, and she found that she had more and more trouble walking. She had pain in her sacroiliac and low back. She only had temporary relief from treatment, and she would not consider that she recovered.

The Appellant described the Second MVA, which was also a high-speed impact. The other vehicle slammed her car against the curb and then drove off. She continued to drive to catch his attention, and then rear-ended the other vehicle when her brakes failed. She had her foot on the brake pedal, and injured her foot, both SI joints and both sides of her pelvis. She saw [Doctor 4] and then [Doctor 1]. She was in an extreme amount of pain, in both sides of the buttocks, adductors, and abdominal wall. Her ability to function was incredibly challenged. She made tiny improvements with treatment, massage and physiotherapy, but was not recovering.

The Fourth MVA was also a high impact collision. The Appellant said that the other vehicle missed a stop sign, and she swerved to miss him, but was unsuccessful, and her car was pushed into the next lane. Her foot was injured from pressing on the break, and her pelvis, back and shoulders were hurt.

The Appellant said that all of the areas of injury listed on Appendix 1 are injuries that she was diagnosed with and for which she received extensive treatment. She thought it was important to show that she had extensive areas of injury, and they all continue to affect her terribly, to this day. She feels that she is only 40% recovered. She tried a work hardening program recently, but she was too fragile. She still needs accommodation in her workplace and still requires physiotherapy.

It is hard for her to manage all her symptoms, including especially her osteitis pubis, and these symptoms have taken over her life. Her career before the MVAs was on a good track, and now there has been a downward spiral. She has tried many varieties of therapy and she has had to pay for them herself recently. She was only working in order to get money to pay for the therapy, but sitting was the worst thing for her. It was only when she went to pelvic floor therapy and stopped sitting for so long that she got some relief.

**Evidence for MPIC:**

Counsel for MPIC did not call any witnesses, but did question the Appellant on cross-examination. He questioned the Appellant regarding her visit to her family physician, [Doctor 3], in February, 1994, when she reported intermittent low back pain. The Appellant acknowledged that she had pre-existing back pain, but said that it never affected her ability to carry on her recreational or work activities, and she never needed any treatment for it.

The Appellant was questioned regarding her testimony in her direct examination that she had some relief from treatment but did not recover. Counsel noted that the Appellant had written to MPIC in June of 2012, and stated that she had "never experienced anything resembling full or partial recovery". Counsel pointed out to the Appellant reports from five of her treating practitioners over the years, who indicated at various points in time that she was either feeling better, or experiencing less pain, or improving. Counsel asked the Appellant whether she would agree that this would reflect at least a partial recovery from the MVAs. The Appellant said that she would not agree; although she did have some improvement, it was not lasting. She still had symptoms and did not recover to the point where she could do her activities.

Counsel questioned the Appellant regarding her assessment by [Doctor 5] in July of 2002. She said that she did not believe that [Doctor 5] treated her professionally and she did not agree with his assessment. She disputed that she exhibited full range of motion of her hips. Counsel further questioned the Appellant regarding her claim that she injured her knee in the Second MVA. The Appellant responded that she recalled attending on [Doctor 1], who said that there was water on her knee. Counsel pointed out that the Appellant attended at Associated Rehabilitation Consultants of Canada Ltd. ("ARCC") the day after the Second MVA, and no knee injury was noted. The Appellant said it was possible that the ARCC records are not accurate, or that she accidentally omitted to mention it. When counsel noted that the ARCC report identified that the Appellant was able to ride a bike and perform various stretching exercises, the Appellant responded that she was instructed to do those activities. Counsel pointed out the reports of other care providers of the Appellant which did not identify any knee injury, and which also indicated that the Appellant had full knee range of motion. He suggested to the Appellant that her knee was not actually injured in the Second MVA. The Appellant said that she did not agree; she had water on her knee. She acknowledged that she was able to move her knee, but it did cause her some difficulty.

The Appellant was questioned regarding the statement in her letter to MPIC from November of 2000 that she dedicated two hours, seven days a week, to stretching and strengthening exercises. She confirmed that she did spend that time doing those exercises, because that's what she was told to do. When asked whether she would agree that it was strenuous, the Appellant said that often it wouldn't feel good, but she was told that pain was her friend. Counsel asked the Appellant whether she tried skating in 1999 and 2000. She said that she did try skating, with the approval and direction of her treating physicians. She did not agree that the skating was strenuous. She said she did not do it for a significant length of time, because it caused her pain.

Counsel questioned the Appellant regarding [Doctor 1] note in his report dated March 31, 2000, that she was "working too hard in her rehabilitation". She did not recall being told that. She said that she would hurt after doing her stretching, although if it was very bad she would stop. She also said that her recovery time after stretching was very long, but her health care providers would keep saying to do it, so she did. Counsel questioned the Appellant regarding the August 3, 2001, report of the physiotherapist [Doctor 6], who said the regime was too intense and was focusing on the wrong muscles. The Appellant said that [Doctor 6] did not tell her anything at the appointment, although she did eventually receive [Doctor 6] report. Counsel suggested to the Appellant that she was doing strenuous activity after the First MVA. The Appellant responded that she was doing what she was instructed to do, and that she never came close to her pre-MVA level of activity. The two hours of stretching and strengthening exercises caused her some difficulty, but she would only continue to the point where she had to stop.

**Submission for the Appellant:**

Counsel for the Appellant provided a written submission as well as oral argument, which was appreciated. Counsel submitted that it was clear that the Appellant had suffered considerably over the four MVAs. In his oral argument, he addressed three of the Appellant's specific claims for PI benefits:

PI #1: Left SI Joint Instability/Dysfunction

Counsel pointed out that in his examination of the Appellant on January 20, 1998, [Doctor 3] noted that she had a tender SI joint. Her physiotherapist, [Doctor 7], in his report dated July 3, 1998, found that she had sacroiliac instability. [Doctor 7] subsequent report dated April 12, 1999, noted ongoing left SI and lumbar signs and symptoms, and in his discharge report dated November 22, 1999, he indicated that his diagnosis of the Appellant was left SI strain. The Initial Physiotherapy

Report of [Doctor 2], dated May 10, 2000, also identified that the Appellant suffered from left sacroiliac regional pain. Counsel submitted that the Appellant is entitled to a PI benefit as a result of her left SI strain, which was caused by the First MVA, and from which she continues to suffer. He submitted that this award could be made under Division 1, Subdivision 2, paragraph 10(a)(i) of Schedule A to the PI Regulation, which provides an award for sacroiliac injury.

PI #2: Hip Flexion/Hip and Buttock Muscle Dysfunction

Counsel noted that the Appellant's claim for a PI benefit with regard to her hip and buttock dysfunction related to the same region of the body as her SI joint dysfunction, so clearly she must have injured that region. He pointed to an x-ray from October 28, 2003, of the Appellant's pelvis and sacroiliac joints, which noted slight degenerative changes in both SI joints. Counsel submitted that the Appellant is entitled to a PI benefit as a result of her hip flexion/hip and buttock muscle dysfunction, which was caused by the First MVA, and from which she continues to suffer. He submitted that this award could be made under Division 1, Subdivision 2, paragraph 12(e)(i) of Schedule A to the PI Regulation, which provides an award for restriction of movement of the hip (flexion).

PI #7: Chronic Osteitis Pubis

Counsel submitted that the Appellant was diagnosed with osteitis pubis, a condition from which she has not recovered. He pointed to the report of [Doctor 1] dated February 18, 2001, in which he stated as follows: "My clinical concern at this point, is that [Appellant] may have accident-related osteitis pubis". [Doctor 1] sent the Appellant for a bone scan on February 26, 2001, which confirmed his diagnosis. Counsel pointed out that [Doctor 3], in his referral letter to the pain clinic dated March 10, 2004, noted that her osteitis pubis had become chronic. Counsel submitted that

the Appellant is entitled to a PI benefit as a result of her chronic osteitis pubis, which was caused by the Second MVA, and from which she continues to suffer.

Because there is no PI award for chronic osteitis pubis available in Schedule A to the PI Regulation, counsel submitted that an analogy could be made pursuant to subsection 129(2) of the MPIC Act. He submitted that the most appropriate analogy would be to Division 1, Subdivision 2, paragraph 2.4(a)(ii), which provides an award for hip joint ankylosis, in a position allowing gait. The panel questioned counsel as to why this particular provision was considered the best analogy, as opposed to, for example, Division 1, Subdivision 2, paragraph 2.4(b), which provides an award for range of motion restriction at the hip. Counsel responded that the Appellant had considerable stiffness due to the osteitis pubis in her hips, but since she could still walk, they considered that the analogy to hip joint ankylosis, in a position which allowed gait, was the most appropriate.

20 Other PI Benefits Sought

The remainder of the Appellant's 23 claims for PI benefits as set out in Appendix 1 were not addressed by counsel in his oral argument, but were addressed in counsel's written submission. In that submission, under a description of the particular PI benefit sought and the relevant provision of Schedule A to the PI Regulation, there is an identical paragraph, as follows:

> The appellant continues to suffer from issues associated with her [particular impairment] because of the [particular] MVA.
>
> A combination of the appellant's testimony and reference to reports from her medical practitioners will be relied upon to show the level of impairment of the appellant.
>
> Through discussions with the appellant, it was determined that the above noted section in the schedule best reflected her level of impairment for the commission's consideration.

Counsel did not otherwise directly address the remaining 20 PI benefits sought by the Appellant. He submitted that the panel should take special care to listen to the testimony of the Appellant, as she was a credible witness and she relayed her impairments. There was a compounding effect of her injuries across the four MVAs. She suffered from quite a bit of pain, and she also suffered from dysfunction, which is different from pain. There is supportive documentation for many of her impairments. The Appellant was following the directions of her care providers and not doing anything unreasonable in her stretching and strengthening exercises. If she did not do as she was directed, she would have faced the possibility of her benefits being terminated. She did do some skating and bike riding, but she was not doing this at a high level, and she did not do any running. The Appellant submits that she is entitled to further PI benefits, under Schedule A to the PI Regulation or under analogous grounds, as enumerated in Appendix 1.

**Submission for MPIC:**

Counsel for MPIC provided a book of authorities together with a written outline of his submission, as well as oral argument, which was appreciated. Counsel noted that the Appellant was involved in four MVAs. She has already received a 6% PI benefit, and is seeking 23 further PI benefits.

No PI Benefit Available for Pain

Counsel submitted that many of the 23 impairments listed on Appendix 1 are based on the Appellant's pain and soft tissue injuries. In some situations a person can be diagnosed with a pain disorder, which might entitle them to a PI benefit for a psychiatric condition, but in this case there has not been a psychiatric diagnosis. Counsel argued that, in the absence of a psychiatric diagnosis, there is no compensation available for the experience of pain, even chronic pain, under the PI legislation.

He referred to the Supreme Court of Canada's decision in *Re Rizzo & Rizzo Shoes Ltd.* ([1998] 1 S.C.R. 27), in which the court approved the following passage from Elmer Driedger in *Construction of Statutes* (2nd ed. 1983) at paragraph 21:

> Today there is only one principle or approach, namely, the words of an Act are to be read in their entire context and in their grammatical and ordinary sense harmoniously with the scheme of the Act, the object of the Act and the intention of Parliament.

The MPIC Act and its regulations must be interpreted in accordance with this interpretive principle. Counsel referred specifically to the definition of "permanent impairment" contained in section 126 of the MPIC Act. It is MPIC's position that although the definition of "permanent impairment" in section 126 may appear to be broad, in that it contains the word "includes", it must be construed in the context of the object and scheme of the MPIC Act and the intention of Parliament, and should in fact be limited to anatomicophysiological deficits and permanent disfigurements. Counsel pointed to the Legislative Debates and Proceedings (Hansard) from July 27, 1993, when the amendments to the MPIC Act were introduced, creating the no-fault PIPP system. The Minister responsible for MPIC at the time stated as follows (at page 6080):

> […] Pain and suffering will not be covered, but those who are dramatically injured will be taken care of, and the people of this province will look around and they will see other jurisdictions begin to follow this example very quickly, because the cost of bodily injury claims and pain and suffering have become unconscionable in terms of our ability to control those costs.

The Uskiw Commission produced a report dated December 15, 1997, in order to review the PIPP provisions of the MPIC Act "to determine if and how it is meeting its original objectives" after three years of operation. Counsel noted that in the Executive Summary of the report, it was stated (at page 4) that "Compensation has increased for weekly indemnity, permanent impairment and death benefits but these increases have been offset by eliminating compensation for non-economic losses, primarily soft tissue injuries and pain and suffering".

Counsel submitted that the PIPP provisions of the MPIC Act do provide coverage for pain, but it is in the form of treatment, rather than in the form of a PI benefit. Looking at the scheme of the MPIC Act, all of the PIs listed in Schedule A to the PI Regulation are objective and identifiable. For example, if a claimant breaks their arm, and then suffers a loss of range of motion, that is measurable and objective. Even in the case of psychiatric conditions, the assessment is objective and the impairment rating for the psychiatric condition changes based on whether follow-up is required on a monthly basis, or less than once a month, for example. However, counsel submitted that pain is subjective and to allow a PI benefit for pain would run counter to the scheme of the MPIC Act.

Counsel pointed out that the Commission has previously considered this issue on at least two occasions. He submitted that these cases, while not binding, provided support for his argument. He noted that in both AC-08-018 and AC-01-130, the Commission did not award a PI benefit to the appellant, and further made comments to the effect that there is no PI benefit available for pain and suffering. Counsel argued further that subsection 129(2) is not intended to be used to compensate for pain where an impairment cannot be found in Schedule A to the PI Regulation.

The Weight to be Placed on the Appellant's Testimony

Counsel submitted that the Appellant's testimony should be viewed with caution, because there were some inconsistencies between her testimony, and letters she had written to MPIC, when compared with the findings of her health care providers.

For example, the Appellant wrote to MPIC in 2012, and said that she had not had even a partial recovery from her MVAs. But it is MPIC's position that there had been a partial recovery after each MVA. Counsel pointed to reports of her various health care providers, which indicated that,

at certain points in time, her condition was improving, or that she was feeling better, which, he argued, indicated at least a partial recovery. However, the Appellant denied this in her testimony. Yet [Doctor 5], in his report dated July 17, 2002, documented that although the Appellant was experiencing diffuse aches and pains, she had full range of motion of her lower back, neck, shoulder, hips and knee, and there was "little to find on examination except for some tenderness about the pelvis". Therefore, contrary to the Appellant's letter and her testimony, MPIC submits that her symptoms did not continue to escalate. Consequently, this should affect the weight to be ascribed to her testimony.

In addition, there was evidence of the Appellant's overly aggressive rehabilitation schedule, as well as skating. [Doctor 6], in her letter dated August 3, 2001, advised that this program was too intense and focused on the wrong muscle groups. In her letter of 2012, the Appellant told MPIC that she did not do strenuous exercise; however, on cross-examination she acknowledged that she did do two hours of strengthening and stretching exercises seven days per week.

Counsel said that MPIC does not dispute that the Appellant is experiencing pain. He noted, however, that the Appellant's claim has been ongoing for more than 20 years and he submitted that this length of time might affect the Appellant's memory. For this reason, he argued that she may not be an accurate historian and he submitted that more weight should be placed on the reports made contemporaneously, with limited weight placed on the Appellant's evidence.

Specific Claims for PI Benefits

Counsel noted that, as set out in Appendix 1, the Appellant is seeking between 70 to 88% of the maximum PI benefit available. He submitted, however, that other than certain spinal abnormalities, (for which she already received a PI benefit), and osteitis pubis (in respect of which MPIC disputes

causation), there is a lack of medical reports documenting a diagnosis of pathological abnormalities.

Counsel then addressed the specific PI benefits sought by the Appellant, as set out in Appendix 1.

PI #1: Left SI Joint Instability/Dysfunction

Counsel acknowledged that the Appellant was diagnosed with a tender left SI joint after the First MVA. However, he pointed out that she was noted to have a tender left SI joint prior to that MVA, as identified in the chart notes of [Doctor 3] on February 18, 1994. He further submitted that the evidence showed that there was a recovery. In [Doctor 1] report of March 31, 2000, he found that the Appellant had full range of motion of the lumbosacral spine and hips, and in his report of May 9, 2000, he stated that she had "limited impairment". Similarly, athletic therapist [Doctor 2], in his report dated May 10, 2000, identified that the Appellant was capable of full function with symptoms and able to work full duties. The Appellant was referred to [Doctor 5] by her physician [Doctor 3]. Counsel submitted that this was because [Doctor 3] consider [Doctor 5] to be an expert. [Doctor 5] found that: "this patient has diffuse aches and pains with little to find on examination except for some tenderness about the pelvis". She had full range of motion of the hips and range of motion of the lumbosacral spine was within normal limits. Counsel submitted that although the Appellant may have had some pain, there is no PI benefit available for pain.

MPIC's HCS consultant, [Doctor 9], reviewed the medical evidence and provided a report dated March 26, 2002, in which he stated: "to the extent [Appellant] sustained a low back strain/sacroiliac sprain as a consequence of the December 27, 1997 MVA, the medical information reviewed indicates that she had functionally recovered from same either as early as a January 20,

1998 family physician assessment or over the course of follow-up with a sports medicine physician up to June 8, 2000." MPIC's HCS consultant, [Doctor 10], also reviewed the medical evidence. She provided a report dated July 14, 2017, in which she stated:

> There were no structural lesions documented at the claimant's hips or left sacroiliac joint at the time of the December 26, 1997 accident. Permanent impairment ratings are not provided for subjective diagnosis of joint or muscle dysfunction. Therefore, no PI entitlements are warranted for the reports of left SI joint instability/dysfunction or hip flexion/hip and buttock muscle dysfunction.

Counsel submitted that there is no evidence that this condition was caused by the MVA, because it was pre-existing. There is no medical evidence that this condition still exists, therefore there is no medical evidence that it is permanent. Further, even if any of that were established, there is no PI benefit available for this condition.

PI #2: Hip Flexion/Hip and Buttock Muscle Dysfunction

Counsel noted that the Appellant's hip pain and buttock pain were identified by [Doctor 3] and [Doctor 1] shortly after the First MVA. However, subsequently, as referred to above, the Appellant was found to have full range of motion of her hips by [Doctor 1] and [Doctor 5]. MPIC's HCS consultant, [Doctor 11], reviewed the medical evidence and provided a report dated November 9, 2000, in which he stated:

> The medical evidence indicates that as of January 1999 [Appellant] had recovered from her motor vehicle collision-related medical conditions to a level where she was able to remain fully functional while performing an exercise program independently that would assist her in minimizing any residual symptoms.

[Doctor 9], in his report dated October 8, 2002, concluded that the First MVA did not cause the Appellant to have any "functional deficits", although she may have had some ongoing pain. [Doctor 10] reviewed the evidence once again and provided a further report dated December 14, 2018. She noted that the Appellant proposed a PI benefit under Schedule A is Division 1,

Subdivision 2, paragraph 12(e)(i), which is applicable to restriction of movement at the hip joint in flexion. She stated:

> On review of the medical information related to this claim, there were no structural anatomical diagnoses reported at the claimant's hips at the time of the December 26, 1997 accident. The reported hip and buttock muscle dysfunction is a soft tissue diagnosis implying painful muscles, usually based on subjective descriptive terms such as spasm and hypertonicity. This is not a diagnosis for which an anatomicophysiological deficit can be reliably identified or reproduced. […]

Counsel submitted that there is no medical evidence that this condition exists, therefore there is no medical evidence that it was caused by the MVA or that it is permanent. Further, even if any of that were established, there is no PI benefit available for this condition.

PI #3 – PI #6: Herniation/Alteration of Cervical and Lumbar Discs C5-6, C6-7, L1-2, L4-5

Although the Appellant may have initially suffered some cervical symptoms after the First MVA, counsel pointed out that her physiotherapist, [Doctor 7], noted in his report dated April 12, 1999, that "Her cervical symptoms and signs are much better controlled." A cervical spine x-ray dated February 3, 2003 found that "Alignment is normal. No disc, bone or joint abnormality is seen." An MRI of the Appellant's cervical spine dated October 10, 2004, found "No disc herniations, cord compression, spinal stenosis or nerve root compression is identified." Counsel acknowledged that in a report of a brain MRI dated January 23, 2017, there was evidence of degenerative changes at the C5-6 level and C6-7 level, including "a very small left posterolateral disc herniation" at C5-6 and "minor posterior disc bulging" at C6-7. He submitted that these findings were years after the MVAs, and also years after the earlier x-ray and MRI which showed normal results, and so there was no causal connection between these findings and the MVAs.

[Doctor 10], in her report dated December 14, 2018, noted that the October 10, 2004, MRI study of the Appellant's cervical spine was normal, and did not identify any disc herniations or other

alterations to the Appellant's cervical spine after the First MVA. She stated that because neither herniation nor alteration were supported radiographically, no PI benefit could be awarded.

With respect to the Appellant's lumbar spine, counsel noted that an x-ray of her lumbosacral spine dated November 6, 2002, identified degenerative changes, as well as narrowing of the intervertebral disc spaces at L5-S1. He pointed out that the Appellant received a PI benefit for the changes at L5-S1. However, there is no mention in this x-ray of any changes to L1-2 or L4-5, the lumbar disc areas for which she is now seeking PI benefits. A further x-ray of the Appellant's lumbosacral spine dated May 13, 2004, revealed a disc protrusion at T11-T12, for which the Appellant also received a PI benefit.

The May 13, 2004, x-ray also identified that "narrowing and desiccation is seen to involve the L1-2" discs, and that at the "L4-5 level there is a shallow posterior disc bulge but no evidence of disc protrusion, stenosis or cord compression." [Doctor 10], in her report dated December 14, 2018, commented on the findings in the May 13, 2004, x-ray: "These are common age related findings and are not specifically directly related to the December 26, 1997 MVA."

Counsel submitted that while the Appellant may have suffered pain in her cervical or lumbar spine, there is no medical evidence that she suffered a herniation or alteration of her C5-6 or C6-7 discs, or an alteration of her L1-2 or L4-5 discs due to any MVA. Further, there is no medical evidence that such a condition is permanent, or that there is an entitlement to a PI benefit for these conditions.

<u>PI #7: Chronic Osteitis Pubis</u>

Counsel acknowledged that the Appellant was diagnosed with osteitis pubis by [Doctor 1], and that [Doctor 1] considered that the condition was caused by the MVA. However, it is MPIC's position that this condition was not caused by the MVA. He noted that [Doctor 12], in his report dated November 6, 2002, confirmed the diagnosis, but did not expressly comment on causation.

[Doctor 9], in his report dated October 8, 2002, stated as follows regarding the Appellant's osteitis pubis:

> […] It is unlikely that this condition occurred as a consequence of the December 26, 1997 motor vehicle accident. It would more likely have occurred in relationship to activities that repetitively loaded the adductors at their insertion into the pubic bones, including brisk walking, running and skating.

In his report dated October 23, 2003, [Doctor 9] stated that he did not change his opinion regarding the osteitis pubis: "this condition does not causally relate to the motor vehicle accidents she has been involved in". He reiterated this view in his report dated September 1, 2004.

Counsel pointed out that [Doctor 5], in his report dated July 17, 2002, noted that the Appellant had been diagnosed with osteitis pubis on the basis of a bone scan and he recommended that the bone scan should be repeated, as it had been one year since it had been performed. It does not appear that this was done. Therefore, counsel submitted that there is nothing in the medical evidence that says the condition of osteitis pubis is permanent. [Doctor 11], in his report dated November 9, 2000, stated that "After reviewing the medical evidence obtained from the documents presently contained in [Appellant] file, it is my opinion that [Appellant] has recovered from the medical conditions arising from the collisions she was involved in […]".

Counsel noted further that there is no medical evidence of reduced pelvic range of motion or reduced hip range of motion. Counsel pointed to the Misericordia Health Centre Urgent Care

Report dated July 11, 2000, which noted full hip range of motion. As well, as noted above, [Doctor 2] and [Doctor 5] had identified full hip range of motion in their reports.

Counsel submitted that even if the Appellant could establish that her osteitis pubis was caused by the MVA, and that it was permanent, she would still need to identify an appropriate PI award. Because there is no PI award for chronic osteitis pubis available in Schedule A to the PI Regulation, an analogy would need to be made pursuant to subsection 129(2) of the MPIC Act. The Appellant has proposed an analogy to Division 1, Subdivision 2, paragraph 2.4(a)(ii), which provides an award for hip joint ankylosis, in a position allowing gait. [Doctor 10], in her report dated December 14, 2018, noted that "ankylosis is defined as immobility of a joint due to fusion of the bones". In her opinion, this rating would not apply as fusion of the hip joints was not documented. Counsel submitted that the proposed PI award was not appropriate, because it forces an assumption of loss of range of motion of the hips, due to fusion of the hips (allowing gait), which is clearly not applicable here. When questioned by the panel whether there is a different analogous provision which counsel would propose, counsel responded that he is not aware of a more appropriate provision; that may be something that would need to be determined by MPIC's HCS department.

Counsel submitted that the Appellant has not established that her osteitis pubis was caused by the MVA, or that it was permanent. Further, even if that were established, the Appellant has not established that she would be entitled to a PI benefit for that condition.

<u>PI #8: Loss of Occupational and Recreational Function</u>

Counsel submitted that loss of occupational function is dealt with by the IRI provisions of the MPIC Act, and no PI award would be applicable. Similarly, there is no PI award available for loss of recreational function, which would seem to be akin to general damages.

PI #9: Chronic Myofascial Pain

Counsel submitted that unless there has been a diagnosis of a psychiatric chronic pain condition, then there is no PI award available for pain. He addressed this in his earlier comments, above.

PI #10: Right SI Joint Instability/Dysfunction

Counsel acknowledged that the Appellant was diagnosed with right SI joint irritation by [Doctor 4] in her Initial Health Care Report dated July 31, 2000. In his report of November 9, 2000, [Doctor 11] noted that the Appellant "developed symptoms in other areas, particularly her ribs, right sacroiliac joint and cervical regions." However, counsel pointed out that [Doctor 11] concluded, as indicated above, by opining that the Appellant "has recovered from the medical conditions arising from the collisions she was involved in". Counsel noted further that, as referred to above, when examined by [Doctor 5], the Appellant was found to have full range of motion in her hips and lower back.

Counsel submitted that the Appellant may have had a sprain or irritation of her right SI joint caused by the Second MVA. However, the medical evidence shows that she recovered from this injury, and therefore there is no medical evidence that it was permanent. Therefore, she is not entitled to a PI benefit.

PI #11 – PI #14: Shoulder Girdle Dysfunction/Right Shoulder Dysfunction/ROM/Impingement

Counsel noted that the Appellant saw [Doctor 4] 10 days following the Second MVA, and [Doctor 4] did not diagnose her as having a shoulder injury, although she did record "palpable discomfort"

in the right interscapular region and mild trapezius irritation. In [Doctor 1] report of November 24, 2000, he documented the Appellant's ongoing shoulder difficulties. He stated as follows:

> As of November 2000,[Appellant] was reassessed regarding her shoulder. She had full glenohumeral range of motion at this time and the rotator cuff strength was improving. She had no impingement signs on that visit.

It is MPIC's position that the Appellant has not established that she had a shoulder injury caused by the MVA; even if that were the case, such an injury had resolved, according to her own physician, [Doctor 1]. Counsel referred to the report of [Doctor 11], dated December 22, 2000, in which [Doctor 11] stated as follows:

> It is my opinion that [Appellant] right shoulder impingement syndrome **could possibly relate** to the collision in question. The medical evidence I obtained from the documents reviewed **does not establish a probable** relationship in my opinion.
>
> Putting the cause/effect relationship aside, the medical evidence does indicate that [Appellant] right shoulder condition did improve and that her impingement signs resolved. […] [emphasis in original]

[Doctor 9] was also of the view that the Appellant's shoulder pain could not be related to the Second MVA. He stated in his report dated October 8, 2002, that there were numerous reasons for this finding, including the "absence of a reported accident induced mechanism to account for same". He further stated:

> Causation aside, the reported right sided impingement syndrome appears to have markedly improved by a November 1, 2000 assessment with the same physician (report of November [2], 2000), when it was noted that glenohumeral range of motion was full, rotator cuff strength was good and there were no impingement signs.

[Doctor 10] commented on the Appellant's claim for these PI benefits in her report dated December 14, 2018. Regarding the Appellant's claim of shoulder girdle dysfunction and right shoulder dysfunction, she noted that there were no anatomicophysiological deficits documented at the Appellant's structures making up her shoulder girdle or her scapula or ribs in connection with the Second MVA, and thus no PI benefits could apply. Regarding the Appellant's claim for a PI

benefit for right shoulder range of motion, [Doctor 10] noted there were no accident related pathoanatomical diagnoses at the right shoulder documented radiographically; and in any event, by November 24, 2000, the Appellant had full glenohumeral range of motion. Regarding the Appellant's claim for right shoulder subacromial impingement syndrome, [Doctor 10] noted that [Doctor 1] stated in a report dated February 18, 2001, that this was another way of referring to supraspinatus tendinopathy. She opined that in order for a PI benefit to be awarded, there must be confirmation by imaging study or direct visualization during surgery, which was not the case here.

Counsel submitted that the Appellant has not established that she has suffered any of the impairments related to the PIs sought in connection with her shoulder, or that if she did suffer those impairments, that they were caused by the MVA or that they were permanent. Further, even if any of that were established, the Appellant has not established that she would be entitled to a PI benefit for any of these conditions.

PI #15 & PI #16: Right Knee Arthrosis and Right Foot Altered Structure/Dysfunction

The Appellant seeks these PI benefits and claims that these impairments arose as a result of the Second MVA. Counsel noted that the Appellant was examined at ARCC on July 11, 2000, the day after the Second MVA. The ARCC report of that examination, dated July 31, 2000, stated that "The lower extremity ranges of motion were full and unremarkable." No knee or foot injury was identified. Similarly, [Doctor 4] report of July 31, 2000, recording a visit of July 20, 2000, does not indicate any knee or foot injury.

With respect to the Appellant's knee, counsel noted that [Doctor 1], in his report dated August 29, 2000, stated that the Appellant's "right knee has become painful and swollen". However, [Doctor 1] did not expressly attribute causation of the knee swelling to the MVA. Further, there was no

specific mention of the Appellant's foot. [Doctor 1] noted that the Appellant "manifested a normal gait, and relatively normal standing alignment". [Doctor 1] mentioned the swollen knee again in his report dated October 15, 2000, while noting that "range of motion was full", again with no mention of causation.

[Doctor 5], who examined the Appellant on July 17, 2002, found that examination of her knee was "unremarkable with full range of motion and no signs of ligamentous laxity or cartilaginous insufficiency". Counsel submitted further that it was significant that the Appellant performed two hours of strengthening and stretching exercises seven days per week.

[Doctor 11], in his report dated November 9, 2000, stated as follows:

> [Doctor 1] identified a condition involving [Appellant] right knee and right shoulder. The medical evidence presently contained in [Appellant] file does not establish a cause/effect relationship between these conditions and either of the motor vehicle collisions she was involved in.

[Doctor 9], in his report dated October 8, 2002, stated that: "Suspected right knee medial compartment arthrosis would not likely have resulted from the motor vehicle accidents in question."

Counsel noted that an August 20, 2015, MRI of the Appellant's right knee identified "mild chondromalacia of the medial femoral condyle". However, he submitted that this MRI was 15 years subsequent to the MVA, and there was no causal connection to the MVA.

With respect to the Appellant's foot, counsel noted that the Appellant, in a letter to MPIC dated November 4, 2002, stated that when she was required to replace her first set of orthotics with a second set in 2002, it was discovered that her foot structure had changed: "[physiotherapist 1], Physiotherapist, Pan Am who prepared my new orthotics himself observed that the arch in the

right foot had dropped quite significantly from the first orthotic made up post ’97 mva.” On cross-examination, the Appellant confirmed that this was her position.

Counsel acknowledged that prior to the Second MVA, in a report from [Doctor 7] dated November 22, 1999, it is noted that the Appellant had a “mild foot deformity” in her left rear foot. He submitted that there is no further mention of any foot injury, however, in any medical reports, and in particular none after the Second MVA. He noted that [Doctor 1], in his report dated December 13, 1999, did not mention a foot injury. [Doctor 1] did, however, recommend that the Appellant cease using the orthotics that she had previously used, because they were “relatively contraindicated” for her.

[Doctor 9], in his October 8, 2002 report, commented on the Appellant’s use of orthotics: “Ms. Dubik obtained custom foot orthotics in late 1998, as treatment for her lower back and left hip pain […]. To the extent foot orthotics were indicated for this purpose, changes in foot posture 3 years later, necessitating new custom orthotics would not have been anticipated.”

[Doctor 10] commented on the Appellant’s claim for these PI benefits in her report dated December 14, 2018. Regarding the Appellant’s knee, she noted that [Doctor 9] opined that it was improbable that the Appellant’s right knee condition was related to the Second MVA, and therefore no PI benefit is applicable. Regarding the Appellant’s claim for a PI benefit for her foot, [Doctor 10] noted that “there were no injuries reported at the right foot or structural lesions documented at the right foot” at the time of the second MVA, and therefore no PI benefit is applicable.

Counsel submitted that the Appellant has not established that she has suffered the impairments related to the PI benefits sought in connection with her knee or her foot, or that if she did suffer

those impairments, that they were caused by the MVA or that they were permanent. Further, even if any of that were established, the Appellant has not established that she would be entitled to a PI benefit for any of these conditions.

PI #17: Bladder Irritability

Counsel referred to a report from [Doctor 3] dated December 17, 2002, in which he described the Appellant's condition when he examined her on September 23, 2002, following the Fourth MVA. The report stated: "She was also noting chronic ongoing bladder irritability, which was much worse after this accident." Counsel submitted that the Appellant's bladder irritability predated the Fourth MVA, and [Doctor 3] didn't make a diagnosis or a causal connection to the Fourth MVA, other than to make a temporal link. [Doctor 9], in his report dated October 25, 2002, opined that medical information had not been submitted which established a probable causal relationship between bladder symptoms and the MVAs that the Appellant had been involved in.

Counsel submitted that there is no evidence that this condition was caused by the MVA, because it seems to have been pre-existing. There is no medical evidence that this condition still exists, therefore there is no medical evidence that it is permanent. Therefore, the Appellant has not established that she is entitled to a PI benefit for this condition.

PI #18 – PI #21: Segmental Dysfunction of the Spine OA/AA, C2-3, L2-3 and L3-4

Counsel noted that [Doctor 10], in her report dated December 14, 2018, and said that segmental dysfunction of the spine "is a term used by treating practitioners to describe pain and dysfunction […]".

Counsel pointed out that an x-ray of the Appellant's cervical spine dated February 3, 2003 was normal. Similarly, an MRI report from October 12, 2004, of the Appellant's cervical spine was

normal. An x-ray of the Appellant's lumbosacral spine dated November 6, 2002, showed degenerative changes with narrowing of the disc space at L5-S1, but no other abnormality. The Appellant did receive a PI benefit with respect to the disc changes at L5-S1. Counsel acknowledged that an MRI of the Appellant's lumbar spine dated September 12, 2016, showed a "mild broad-based disc bulge" at L3-4. He submitted, however, that this was 14 years subsequent to the Fourth MVA, and that there is no medical evidence causally connecting this disc bulge to that MVA.

There is no PI award for segmental dysfunction of the spine available in Schedule A to the PI Regulation. Therefore, an analogy would need to be made pursuant to subsection 129(2) of the MPIC Act. The Appellant has proposed an analogy to Division 1, Subdivision 3, paragraph 1(e)(i) for the cervical spine, and to paragraph 3(e) for the lumbar spine. In her report of July 14, 2017, [Doctor 10] stated that "These ratings are only provided when there is documented a radiographic evidence of instability and slippage of one vertebra on another […]". Counsel submitted that the proposed PI award was not appropriate, because there is no radiographic evidence of dysfunction here. When questioned by the panel whether there is a different analogous provision which counsel would propose, counsel responded that he is not aware of a more appropriate provision.

Counsel submitted that the Appellant has not established that she has suffered any of the impairments related to the PIs sought in connection with segmental dysfunction of her spine, or that if she did suffer those impairments, that they were caused by the MVA or that they were permanent. Further, even if any of that were established, the Appellant has not established that she would be entitled to a PI benefit for any of these conditions.

<u>PI #22 & PI #23: Enhancement Factors – SI Joint Instability, Shoulder Girdle Dysfunction</u>

Section 2 of the PI Regulation provides that where an impairment exists symmetrically, that is, on both sides of the body, then an enhancement factor (.25) can be applied and an additional PI benefit can be awarded. The Appellant is seeking an enhancement in connection with her SI joint instability, on the basis that both her left and right SI joints suffered from a permanent impairment. Similarly, she is seeking an enhancement in connection with her shoulder girdle, on the basis that both her left and right shoulders suffered from a permanent impairment.

Counsel submitted that the Appellant is not entitled to a PI benefit based on either of the enhancement factors, as she has failed to establish that either of her SI joints suffered from a permanent impairment, and she has also failed to establish that either of her shoulders suffered from a permanent impairment.

Conclusion

Counsel submitted that the Appellant suffered primarily from soft tissue injuries and pain complaints as a result of the four MVAs. She has been seen by numerous health care practitioners, and many have said her symptoms have resolved. Her own treating practitioner, [Doctor 3], in his report dated July 5, 2001, stated that "really I am at a complete loss to explain all of her symptoms". Counsel pointed out that [Doctor 5], in his report dated July 17, 2002, stated: "In summary, this patient has diffuse aches and pains with little to find on examination except for some tenderness about the pelvis."

MPIC's HCS consultants, [Doctor 11] and [Doctor 9], reviewed all of the medical evidence, as referred to above, and found that there was no evidence to support the Appellant's claims that she suffered from any impairments that were caused by any of the MVAs. MPIC's HCS consultant [Doctor 10] also reviewed the medical evidence in the context of Schedule A to the PI Regulation,

and opined that the Appellant was not entitled to any further PI benefits. Counsel submitted that the Appellant has not responded to any of the opinions provided by these physicians other than through her own testimony, and a recounting of her symptoms is insufficient to meet the onus upon her. He submitted that the Appellant's appeal should be dismissed.

**Discussion**:

As noted above, PI benefits are governed under subsection 127(1) of the MPIC Act, which provides that "a victim who suffers permanent physical or mental impairment because of an accident is entitled to a lump sum indemnity" for the PI. Section 1 of the PI Regulation provides that "Compensation for permanent impairments shall be determined on the basis of Schedule A". Schedule A to the PI Regulation lists permanent deficits of physical or mental function, as well as disfigurements that may have been caused by an accident. It sets out the amount of compensation to be awarded for each type of PI, expressed as a percentage of the maximum indemnity (originally $100,000, now indexed).

In order to be entitled to further PI benefits, the Appellant must establish, on a balance of probabilities, that there are additional PI benefits to which she is entitled, as a result of one, or more, of the MVAs. The Appellant is seeking 23 further PI benefits, as set out in Appendix 1. For each of these PI benefits, the onus is on the Appellant to establish, on a balance of probabilities, that:

a) She suffered the identified impairment; and
b) The impairment was caused by an MVA; and
c) The impairment was permanent; and
d) There is a PI benefit available for the impairment.

The Appellant must establish all 4 components in respect of each PI benefit sought; failure to establish even one component of a particular claim will be fatal to that claim.

We note that [Doctor 10], in her report dated December 14, 2018, provided the following definitions:

> **Impairment** is an alteration from what is deemed normal of an individual's body part or organ system and its functioning. It is a loss or abnormality of the physiological or anatomical structure or function. **Impairment** is any condition that interferes with a person's ability to perform their activities of daily living. These activities include but are not limited to self-care, feeding, dressing, transferring, ambulation, communication and social interaction in the home or workplace. An impairment is considered **permanent** when it becomes static or stable and no further medical treatment can reasonably be anticipated to improve a person's function or impairment.
> [emphasis in original]

The Appellant did not submit any alternate definition of the terms "impairment" or "permanent". We consider [Doctor 10] definition of those terms to be reasonable and we accept them.

As indicated, section 1 of the PI Regulation provides that PIs and their respective benefits will be found in Schedule A to the PI Regulation. However, subsection 129(2) of the MPIC Act allows MPIC to determine a benefit for a PI where that impairment is not found in Schedule A. The Appellant is seeking benefits for numerous PIs that do not appear in Schedule A. Under paragraph 184(1)(b) of the MPIC Act, following an appeal hearing the Commission may make any decision that MPIC could have made. Therefore, should the Appellant establish, on a balance of probabilities, that she suffered an impairment, that it was caused by the MVA and that it was permanent, the panel could determine the appropriate benefit for that PI under subsection 129(2) of the MPIC Act.

<u>Whether a PI Benefit is Available for Pain</u>

Counsel for MPIC argued that, in the absence of a psychiatric diagnosis, there is no PI benefit available solely for the experience of pain. He referred to the Legislative Debates that took place during the introduction of the PIPP provisions of the MPIC Act, as well as the Uskiw Report, to argue that upon that introduction, it was not intended that there be ongoing compensation for pain and suffering. We agree that this is the case, and we agree with the statement from the Commission in its earlier decision, AC-01-130, that "there is no provision in the MPIC Act to cover the concept of damages or compensation for 'pain and suffering'".

In the course of his argument, counsel for MPIC also submitted that the definition of "permanent impairment" found in section 126 of the MPIC Act should be construed narrowly. He argued that notwithstanding that the definition states that a permanent impairment "includes" permanent anatomicophysiological deficits and permanent disfigurements, it should be limited to those things and nothing else should be considered as falling within the definition. However, counsel did not provide the panel with any law to support his argument. We would also note that this interpretation would appear to be contrary to section 6 of the Interpretation Act, which would mandate a "fair, large and liberal interpretation […]".

[Doctor 10], in her report dated December 14, 2018, provided the following definition: "An **anatomicophysiological deficit** pertains to an alteration in a person's anatomy (such as a fracture, dislocation, cartilage tear, tendon tear or rupture, ligament tear, joint separation) which results in a change in the physiological function of the structure affected" [emphasis in original]. This definition would obviously not encompass any kind of mental impairment, which is clearly included within the meaning of "permanent impairment" by subsection 127(1) of the MPIC Act. Thus, anatomicophysiological deficits and permanent disfigurements cannot be an exhaustive list of the permanent impairments that fall within the definition of the term in section 126, and

therefore, we find that we cannot agree with counsel's argument, that in section 126 of the MPIC Act, the word "includes" should be read as "means".

We note that, in the course of his argument, counsel for MPIC referred to another prior decision of the Commission, AC-08-018, in which the Commission held that the PI scheme in the MPIC Act did not provide a basis for awarding a benefit based on the appellant's soft tissue injury and pain complaints in the absence of pathological abnormalities diagnosed as a result of the motor vehicle accident. As indicated above, we agree with MPIC's argument that it is not within the scheme of the MPIC Act to provide an award based solely on pain. However, given the above analysis regarding section 126 of the MPIC Act, we point out that it may be possible, depending on the particular circumstances, that a permanent impairment benefit may be available to an appellant in the absence of pathological abnormalities diagnosed as a result of the motor vehicle accident (one example would be in a situation of a permanent mental impairment, where there would be a diagnosis of a permanent mental injury as a result of the motor vehicle accident, but there may not be a diagnosis of a pathological abnormality).

The Appellant's Testimony

Counsel for MPIC argued that the Appellant's testimony should be viewed with caution. He noted certain inconsistencies between her testimony and the findings of her health care providers. He submitted that more weight should be placed on the reports made contemporaneously, with limited weight placed on the Appellant's evidence. Counsel for the Appellant submitted that the Appellant was a credible witness who relayed her impairments.

Given that we will be addressing each of the Appellant's 23 claims for a PI benefit directly, we do not find it necessary to deal with this issue separately, as we will address each specific PI claim

below. However, we note that with respect to each specific claim for a PI benefit, the Appellant must satisfy the onus upon her (i.e. whether she has an impairment, whether it was caused by the MVA, whether the impairment is permanent, and whether there is a PI benefit available for that impairment). The Appellant's testimony is one factor, among several, that the panel has considered with respect to each claim.

Specific Claims for PI Benefits

As indicated above, the Appellant seeks 23 further PI benefits, pursuant to (or analogous to, as the case may be) the provisions of Schedule A to the PI Regulation, as enumerated in Appendix 1. Counsel for the Appellant made specific oral arguments with respect to three of those PI benefits. Counsel for MPIC addressed all of the claims in detail.

The panel has carefully considered the testimony of the Appellant and the arguments of counsel. We have also carefully reviewed the medical evidence. We will address each claim below.

PI #1: Left SI Joint Instability/Dysfunction

[Doctor 3], who saw the Appellant on January 20, 1998, three weeks after the first MVA, noted signs of a tender left SI joint. [Doctor 7], in his report dated November 22, 1999, diagnosed the Appellant with left SI strain. The Appellant's athletic therapist, [Doctor 2], in his report dated May 10, 2000, also identified left sacroiliac regional pain. The Appellant testified regarding the pain in her left SI joint following the first MVA. However, counsel for MPIC pointed out that there is also evidence that she was noted to have a tender left SI joint prior to the First MVA, as identified in the chart notes of [Doctor 3] on February 18, 1994.

While we may have been prepared to consider whether the Appellant's left SI joint instability was caused by the First MVA, there is still the question of whether this condition is permanent. In [Doctor 1] report of March 31, 2000, he found that the Appellant had full range of motion of the lumbosacral spine and hips, and in his report of June 12, 2000, he noted that "Examination today was essentially unremarkable […]". [Doctor 5], in his report dated July 17, 2002, found that the Appellant had full range of motion of the hips and range of motion of the lumbosacral spine was within normal limits. We also note [Doctor 9] March 26, 2002, opinion that the Appellant had "functionally recovered" from this condition by not later than June 8, 2000.

As indicated, a number of issues were raised by the parties regarding the Appellant's left SI joint instability/dysfunction, including that it may have been pre-existing. For our purposes, it is sufficient to find, as we do, that the weight of the evidence establishes, on a balance of probabilities, that any left SI joint instability/dysfunction suffered by the Appellant resolved and that it was not permanent.

As a result, we find that the Appellant has not established, on a balance of probabilities, that she is entitled to a PI benefit for this condition.

PI #2: Hip Flexion/Hip and Buttock Muscle Dysfunction

The Appellant is seeking an award under Division 1, Subdivision 2, paragraph 12(e)(i) of Schedule A of the PI Regulation, which provides a PI benefit for restriction of movement of the hip (flexion), in respect of what appears to be two distinct conditions: (i) hip flexion; and (ii) hip and buttock muscle dysfunction.

With respect to hip flexion, the Appellant testified regarding tightness in her hip flexors following the First MVA. However, subsequently, the Appellant was found to have full range of motion of her hips. [Doctor 1], in his report dated December 13, 1999, assessed her hip range of motion and stated that it was "better than normal". In his report of March 31, 2000, he also found that the Appellant had full range of motion of her hips. [Doctor 5], in his report dated July 17, 2002, made the same finding. Although the Appellant, in her cross-examination, disputed this finding of [Doctor 5], there is no medical evidence which contradicts it, and the Appellant did not provide any objective evidence to show that she had any restriction of movement of her hips.

Based on the weight of the evidence, we find that the Appellant has not established, on a balance of probabilities, that she had any restriction in hip flexion due to the First MVA. As result, we find that the Appellant has not established, on a balance of probabilities, that she is entitled to a PI benefit for this condition.

With respect to the Appellant's hip pain and buttock pain, this was identified by [Doctor 3] in his report dated March 16, 1998. [Doctor 1] also noted this pain, referring to it in his report dated December 13, 1999, as "chronic benign hip and buttock muscle dysfunction". As noted above, the Appellant testified regarding pain in her hip following the First MVA. However, we note that the objective medical evidence does not indicate that the Appellant was impaired by this condition. The Appellant's treating physician, [Doctor 3], in his March 16, 1998, report, while noting the Appellant's pain in this area, nevertheless identified that the Appellant was capable of full function with symptoms and able to work full duties. The Appellant's athletic therapist, [Doctor 2], in his report dated May 10, 2000, indicated the same thing. We also note [Doctor 11] November 9, 2000, opinion that, as of January 1999, the Appellant had recovered from her MVA-related medical conditions to a level where she was able to remain "fully functional".

Based on all of the evidence, we find that the Appellant has not established, on a balance of probabilities, that her hip and buttock muscle dysfunction was an impairment. As a result, we find that she has not established, on a balance of probabilities, that she is entitled to a PI benefit for this condition.

PI #3 – PI #6: Herniation/Alteration of Cervical and Lumbar Discs C5-6, C6-7, L1-2, L4-5

The Appellant is seeking PI benefits in respect of the herniation of her C5-6 disc and the post-traumatic alteration of her C6-7, L1-2 and L4-5 discs. She testified regarding pain in her cervical and lumbar spine following the First MVA, which she said still continues. However, the objective medical evidence does not support the Appellant's contention that the First MVA caused a herniation or alteration of her C5-6, C6-7, L1-2 or L4-5 discs. As noted above, a 2003 cervical spine x-ray and a 2004 cervical spine MRI were both normal. Although a 2017 brain MRI identified "a very small left posterolateral disc herniation" at C5-6 and "minor posterior disc bulging" at C6-7, we note that this MRI was taken 15 was years after the Fourth MVA, and 13 years after the earlier x-ray and MRI, which had both showed normal results. We find that there is no clear temporal link or causal connection between the findings on this MRI and the MVAs.

Similarly, a 2002 x-ray of the Appellant's lumbosacral spine contains no mention of any changes to her L1-2 or L4-5 discs. Subsequently, a 2004 x-ray identified that "narrowing and desiccation is seen to involve the L1-2" discs, and that at the "L4-5 level there is a shallow posterior disc bulge but no evidence of disc protrusion, stenosis or cord compression." [Doctor 10], in her report dated December 14, 2018, stated that: "These are common age related findings and are not specifically directly related to the December 26, 1997 MVA." The Appellant did not provide any medical evidence contrary to the opinion of [Doctor 10], and we accept [Doctor 10] opinion.

Based on all of the evidence, we find that the Appellant has not established, on a balance of probabilities, that she suffered a herniation of her C5-6 disc, or an alteration of her C6-7, L1-2 or L4-5 discs; nor, even if she did, that these conditions were caused by the MVA. As a result, we find that the Appellant has not established, on a balance of probabilities, that she is entitled to a PI benefit for any of these conditions.

PI #7: Chronic Osteitis Pubis

We note that in connection with this claim, the Appellant set out in Appendix 1, in addition to her claim for a PI benefit for chronic osteitis pubis, a claim for a PI benefit for adductor dysfunction and a claim for a PI benefit for hip range of motion. As indicated above, we have found that the evidence does not support the Appellant's claim for a separate PI benefit due to any restriction of movement of her hips. Counsel for the Appellant, in argument, did not advance a separate claim for PI benefits in respect of these areas. Accordingly, we considered adductor dysfunction only to the extent that it was relevant to the Appellant's claim for a PI benefit for osteitis pubis.

The parties agree that the Appellant was diagnosed with osteitis pubis after the Second MVA. However, MPIC disputes that the condition was caused by the MVA, and that it is permanent.

With respect to issue of causation, we note that the Appellant testified that she injured her pelvis in the Second MVA. [Doctor 4], who saw the Appellant on July 20, 2000, ten days after the Second MVA, noted symptoms of diffuse pelvis and bilateral groin pain and found that the Appellant had "Hip adductors taut bilaterally with origin site pain". In [Doctor 1] report dated February 18, 2001, he noted that:

> In my most recent assessment of [Appellant], I discovered that she has significant tenderness over the symphysis pubis. Tenderness on or around this site was documented by [Doctor 4], in her original assessment of [Appellant] after the most recent collision in question. My clinical concern at this point, is that [Appellant] may have accident-related osteitis pubis.

A bone scan on February 26, 2001, confirmed the diagnosis. [Doctor 1] confirmed to MPIC, in response to their letter dated April 18, 2001, that the Appellant's medical condition did arise from the MVA. [Doctor 12], in his report dated November 6, 2002, noted that the Appellant had chronic pelvic pain since July, 2000, and found that the Appellant had low grade osteitis pubis, although he did not expressly state that the condition was caused by the MVA.

MPIC's HCS consultant, [Doctor 9], was of the opinion that the Appellant's osteitis pubis was not caused by the MVA. He stated, in his report dated October 8, 2002, that: "It would more likely have occurred in relationship to activities that repetitively loaded the adductor tendons at their insertion into the pubic bones, including brisk walking, running and skating". We note that the Appellant testified that she did do some skating, but said she did not skate for a significant length of time. Counsel for the Appellant submitted that her skating was not at a high level, and she did not do any running.

We have weighed the evidence of [Doctor 1], [Doctor 4] and [Doctor 12] against [Doctor 9] forensic assessment. [Doctor 1], [Doctor 4] and [Doctor 12] all had the opportunity to personally examine and treat the Appellant, assessing her credibility and obtaining her medical history. [Doctor 1] was of the view that the Appellant's osteitis pubis was caused by the Second MVA, and the reports of [Doctor 4] and [Doctor 12] support this opinion. The panel has given greater weight to [Doctor 1] opinion and the reports of [Doctor 4] and [Doctor 12] than to the opinion of [Doctor 9], who did not have the opportunity to examine the Appellant.

We find that the weight of the evidence establishes, on a balance of probabilities, that the Appellant's osteitis pubis was caused by the Second MVA.

We note that the condition of osteitis pubis falls within the definition of "impairment" as set out above, in that it involves an alteration from the normal functioning of the Appellant's body. There is also evidence that the Appellant was impaired by this condition within the meaning of that definition. The Appellant testified that after the Second MVA her ability to function was incredibly challenged, and that sitting was the worst thing for her, which seems to indicate that she suffered from a degree of postural intolerance. [Doctor 1], in his report dated February 18, 2001, stated as follows: "Osteitis pubis is a condition which can lead to abdominal muscle discomfort, hip muscle discomfort, and groin discomfort. […] This may explain her refractory course despite the athletic therapy to-date." Chiropractor [Chiropractor 1], in his report dated April 18, 2001, noted that the Appellant had complaints of right and left groin pain and abdominal pain. He indicated that she was capable only of "less than full function due to symptoms and/or functional deficits", and able to work only modified duties. [Doctor 3], in a report to MPIC dated September 4, 2001, recommended modified work hours. [Doctor 9], in a report dated September 20, 2001, while not in agreement with respect to causation, noted that the Appellant's family physician and her physiotherapist, as well as the third-party physiotherapist, were in agreement with respect to further treatment, and he therefore supported the modified work hours recommended by [Doctor 13]. On the basis of this evidence, we find that the Appellant's osteitis pubis constituted an impairment.

With respect to whether the Appellant's osteitis pubis is permanent, we note that [Doctor 2], in his report dated January 24, 2001, stated that the Appellant had "ongoing subjective pain reports of

hip and groin pain, which remained consistent over the entire course of treatment". [Doctor 1], in his February 18, 2001, report stated that osteitis pubis "is notoriously difficult to treat and can have a long period of convalescence". [Doctor 6], in her report dated August 3, 2001, noted that "The condition of osteitis pubis is very slow to resolve". [Doctor 3], in his letter dated March 10, 2004, noted that the Appellant's osteitis pubis had become chronic.

Counsel for MPIC pointed out that [Doctor 5], in his report dated July 17, 2002, noted that the Appellant had been diagnosed with osteitis pubis on the basis of a bone scan and he recommended that the bone scan should be repeated, as it had been one year since it had been performed. While there is no evidence before us that this bone scan was repeated, the absence of a follow-up bone scan does not cause us to draw a negative inference regarding the continued existence of the Appellant's osteitis pubis.

The Appellant testified that she has a constant imbalance throughout her pelvis. She said that sitting continues to cause her pain, and the osteitis pubis is especially hard to manage; it continues to cause her significant difficulty and she has not recovered from it. Counsel for MPIC argued that [Doctor 11] found otherwise, in his report of November 9, 2000, in which he stated: "After reviewing the medical evidence obtained from the documents presently contained in [Appellant] file, it is my opinion that [Appellant] has recovered from the medical conditions arising from the collisions she was involved in […]". We note, however, that [Doctor 11] report is dated November 9, 2000, which is three months prior to the February 18, 2001, report of [Doctor 1] which confirmed the Appellant's diagnosis of osteitis pubis. Therefore, it is apparent that [Doctor 11] did not have an opportunity to consider whether the Appellant had recovered from her osteitis pubis, and so we give his comments little weight in this context. We accept the Appellant's testimony, that this condition continues to cause her difficulty.

The only evidence before us tending to suggest a non-permanent impairment is an indication that the Appellant returned to work on a full-time basis, for what appears to be a period of approximately nine months, beginning in early December, 2001. However, we note that even though she was working full-time, the Appellant required continuous treatment, and after five months, she faced limitations in her function. A report from physiotherapist [Physiotherapist 2] dated December 4, 2001, states that the Appellant is: "Working full time and able to cope with symptoms if she sees her massage therapist 2x/week and physio 1x/2 weeks". Subsequently, a report from [Doctor 3] dated May 8, 2002, indicates that the Appellant had the capacity to work full duties; however it also indicates significant limitations in her function, including inabilities related to physical activities, home maintenance, weight-bearing activity, social activity, and specific limitations related to work, including limited sitting tolerance and required accommodations. The Appellant's physiotherapist [Physiotherapist 3] assessed her three days following the Fourth MVA and provided a report dated October 15, 2002, in which he indicated that the Appellant was able to work only modified duties, and capable only of less than full function due to symptoms and/or functional deficits. [Doctor 9] had an opportunity to review additional evidence regarding the Fourth MVA and provided a further report dated September 7, 2010, in which he stated that: "[…] it is my updated opinion that the force of the September 13, 2002 MVA would be consistent with having induced perturbation of [Appellant] pre-accident pelvic region symptoms […]" (although he subsequently confirmed that he did not change his opinion with respect to causation of the Appellant's osteitis pubis).

Accordingly, while there is some conflicting evidence, we find that the weight of all of the evidence establishes, on a balance of probabilities, that the Appellant's osteitis pubis is permanent.

As a result, based on all of the evidence, we find that the Appellant has met the onus to establish, on a balance of probabilities, that she suffers from this impairment, that it was caused by the MVA, and that it is permanent. Therefore, we find that the Appellant is entitled to a permanent impairment benefit in respect of her osteitis pubis.

Because there is no PI award for chronic osteitis pubis available in Schedule A to the PI Regulation, an analogy would need to be made pursuant to subsection 129(2) of the MPIC Act. The Appellant has proposed an analogy to Division 1, Subdivision 2, paragraph 2.4(a)(ii), which provides an award for hip joint ankylosis, in a position allowing gait. Counsel for MPIC argued that this analogy was not appropriate. [Doctor 10], in her report dated December 14, 2018, agreed, on the basis that the proposed provision more properly applies where there is a loss of range of motion of the hips due to fusion of the hip joints, which is not the case here. We accept [Doctor 10] opinion that the Appellant's proposed analogy is not appropriate. When asked, counsel for MPIC suggested that MPIC's HCS department may be able to determine a more appropriate provision to use as an analogy under subsection 129(2).

We will return this matter to MPIC's case manager, for a determination as to the appropriate amount of the PI benefit to be awarded to the Appellant for osteitis pubis pursuant to subsection 129(2) of the MPIC Act.

PI #8: Loss of Occupational and Recreational Function

We agree with counsel for MPIC that loss of occupational function is dealt with by the IRI provisions of the MPIC Act. We note that loss of recreational function is dealt with under other provisions of the MPIC Act, such as section 138, which deals with rehabilitation. We find that the

Appellant has failed to establish, on a balance of probabilities, that there is a PI benefit available for either loss of occupational function or loss of recreational function.

Accordingly, we find that the Appellant has not established, on a balance of probabilities, that she is entitled to a PI benefit for either of these conditions.

PI #9: Chronic Myofascial Pain

In our comments above, we indicated that we agree with the argument of counsel for MPIC, that in the absence of a psychiatric diagnosis, there is no PI benefit available solely for the experience of pain. We therefore find that the Appellant has failed to establish, on a balance of probabilities, that there is a PI benefit available for chronic myofascial pain.

Accordingly, we find that the Appellant has not established, on a balance of probabilities, that she is entitled to a PI benefit for this condition.

PI #10: Right SI Joint Instability/Dysfunction

The Appellant was diagnosed with right SI joint irritation by [Doctor 4], who saw her on July 20, 2000, 10 days after the Second MVA. Physiotherapist [Physiotherapist 2], in her report dated July 26, 2001, also noted right SI joint dysfunction. The Appellant testified regarding the continuing pain in her right SI joint.

While we may have been prepared to consider whether the Appellant's right SI joint instability was caused by the Second MVA, there is still the question of whether this condition is permanent. As noted above, [Doctor 5], in his report dated July 17, 2002, found that the Appellant had full range of motion in her hips, and range of motion of the lumbosacral spine within normal limits.

[Doctor 12], in his report dated November 6, 2002 stated: "On examination today, she had close to full range of motion of her LS spine. […] Hip range of motion was relatively well preserved." We also note the comments of [Doctor 11] in his report of November 9, 2000, who noted that the Appellant developed symptoms in her right sacroiliac joint, and opined that she "has recovered from the medical conditions arising from the collisions she was involved in".

We find that the weight of the evidence establishes, on a balance of probabilities, that any right SI joint instability/dysfunction suffered by the Appellant resolved and that it was not permanent.

As a result, we find that the Appellant has not established, on a balance of probabilities, that she is entitled to a PI benefit for this condition.

PI #11 – PI #14: Shoulder Girdle Dysfunction/Right Shoulder Dysfunction/ROM/Impingement

The Appellant is seeking PI benefits for shoulder girdle dysfunction (bilateral), right shoulder scapular thoracic dysfunction, right shoulder range of motion (ROM), and right shoulder subacromial impingement syndrome. MPIC disputes that the Appellant suffered any of these impairments, that they were caused by the MVA, or that they were permanent.

We have reviewed the documentary medical evidence, and we note that there was very little evidence regarding bilateral shoulder girdle dysfunction. There is evidence regarding the Appellant's right shoulder. [Doctor 1], in his report dated October 15, 2000, noted that the Appellant's right shoulder manifested "tender supraspinatus tendon" and he diagnosed the Appellant with "right shoulder subacromial impingement" (also referred to by [Doctor 1] in his reports as supraspinatus tendinopathy and scapular dysfunction). There is no separate evidence relating to scapular dysfunction, or range of motion of the Appellant's right shoulder, outside the

context of the assessment of the Appellant's subacromial impingement syndrome. We will therefore restrict our analysis below to the Appellant's right shoulder subacromial impingement syndrome.

While we may have been prepared to consider that the Appellant's right shoulder subacromial impingement syndrome was caused by the Second MVA, there is still the question of whether this condition is permanent. We note that in [Doctor 1] report of November 24, 2000, he indicated that, as of November 2000, the Appellant had "full glenohumeral range of motion" and no impingement signs. [Doctor 11] and [Doctor 9] were both of the opinion that the Appellant's impingement syndrome had resolved at that point in time, based on [Doctor 1] report. This would appear to be consistent with [Doctor 1] report.

Subsequently, the Appellant was seen by athletic therapist [Athletic Therapist 1], who provided a report dated January 4, 2001. [Athletic Therapist 1] noted that upon examination she found "winging of her right scapula, as well as a large muscle adhesion in her right trapezius and levator scapula muscles". MPIC contacted athletic therapist [Doctor 2] and asked him to comment on [Athletic Therapist 1] report. He provided a report dated January 24, 2001, and with respect to the Appellant's shoulder, he stated: "[Appellant] was being treated for right scapular thoracic dysfunction with active rehabilitation and massage, which was resolving well […]". [Doctor 1] reassessed [Appellant] again on February 15, 2001, and in his report dated February 18, 2001, noted that she had "mild scapular dysfunction bilaterally with scapular protraction".

The Appellant did not testify specifically with respect to any ongoing difficulties that she faces with respect to her shoulder, other than to say broadly that the impairments listed on Appendix 1 were all areas of injury that she had been diagnosed with.

[Doctor 1] found that the Appellant had full glenohumeral range of motion, and showed no impingement signs, as of November 24, 2000, as indicated in his report of that date. [Doctor 11] and [Doctor 9] both opined that the Appellant's shoulder condition had resolved as of that date. While [Doctor 1] subsequently noted some mild symptoms, as did [Athletic Therapist 1], [Doctor 2] indicated that as a result of athletic therapy treatment, this condition was "resolving well", and the Appellant did not testify regarding any ongoing shoulder difficulties. Therefore, while there is some conflicting evidence, we find that the weight of the evidence establishes, on a balance of probabilities, that the Appellant's subacromial impingement syndrome resolved and that it was not permanent.

Accordingly, we find that the Appellant has not established, on a balance of probabilities, that she is entitled to a PI benefit for any of these conditions.

PI #15 & PI #16: Right Knee Arthrosis and Right Foot Altered Structure/Dysfunction

With respect to the Appellant's claim for a PI benefit for right knee arthrosis/chondromalacia, she testified that she injured her right knee in the Second MVA. She acknowledged that she was able to move her knee, but said that it did cause her some difficulty. She did not describe any ongoing difficulties that she faces with respect to her knee.

No knee injury was recorded in the reports of either [Doctor 2] or [Doctor 4], who both saw the Appellant in July, 2000, shortly after the Second MVA. [Doctor 1] saw the Appellant on August 28, 2000, and did identify a condition involving the Appellant's knee. He provided several reports to MPIC, as follows:

1. August 29, 2000, in which he stated that the Appellant "has evidence of right knee effusion with suspected meniscal pathology".
2. October 15, 2000, in which he noted that the range of motion of the Appellant's knee was full, with medial joint line tenderness. He provided his assessment of Appellant, listing four conditions, one of which was "right knee suspected medial compartment arthrosis".
3. November 2, 2000, which included the same knee condition.
4. November 24, 2000, which specifically stated that his comments were in respect of "[Appellant] motor vehicle collision-related conditions". In that report, he noted that after his first assessment of the Appellant "the patient's right knee joint was x-rayed and the joint spaces were well preserved." He stated further that after her latest assessment, "her right knee demonstrated ongoing medial joint line tenderness and swelling".
5. February 18, 2001, he indicated that upon further reassessment, the Appellant "has some right lateral knee pain, which is not associated with any significant swelling, locking or giving away".

[Doctor 5], who examined the Appellant on July 17, 2002, found that: "Examination of the hip and knee is unremarkable with full range of motion and no signs of ligamentous laxity or cartilaginous insufficiency bilaterally." [Doctor 9], in his report dated October 8, 2002, stated that: "Suspected right knee medial compartment arthrosis would not likely have resulted from the motor vehicle accidents in question." [Doctor 11], in his report of November 9, 2000, was also of this opinion. An MRI of the Appellant's right knee dated August 20, 2015 identified "mild chondromalacia of the medial femoral condyle".

The Appellant seeks a PI benefit in respect of her right knee for right knee arthrosis and/or right knee chondromalacia. With respect to right knee chondromalacia, the only evidence regarding this

condition consists of an MRI from 2015, which is 15 years subsequent to the Second MVA. We find that there is no clear temporal link or causal connection between the findings on this MRI and the Second MVA, and therefore we find that the Appellant has not established, on a balance of probabilities, that her right knee chondromalacia was caused by the Second MVA. Accordingly, we find that the Appellant has not established, on a balance of probabilities, that she is entitled to a PI benefit for this condition.

With respect to right knee arthrosis, we note that although [Doctor 1] made several comments regarding the Appellant's knee in his reports, he did not diagnose the Appellant with right knee arthrosis, but only with "right knee **suspected** medial compartment arthrosis" (emphasis added), in his reports of October 15 and November 2, 2000. In his subsequent reports, he no longer referred even to suspected arthrosis, but only to tenderness and pain. Based on this evidence, we find that the Appellant has not established, on a balance of probabilities, that she suffered right knee arthrosis. Accordingly, we find that the Appellant has not established, on a balance of probabilities, that she is entitled to a PI benefit for this condition.

With respect to the PI benefit for her right foot altered structure/dysfunction, the Appellant takes the position that the structure of her right foot changed, and that it was due to her use of orthotics. [Doctor 3] had recommended orthotics for the Appellant on January 14, 1999, to relieve "some of her left hip and lower back symptomatology". In a letter to MPIC dated November 4, 2002, she stated that when she was required to replace her first set of orthotics with a second set in 2002, it was discovered that her foot structure had changed: "[Physiotherapist 1], Physiotherapist, Pan Am who prepared my new orthotics himself observed that the arch in the right foot had dropped quite significantly from the first orthotic made up post '97 mva." There is no report from [Physiotherapist 1], himself in evidence. Nor is there any evidence from any of the Appellant's

health care providers describing a foot injury or an alteration to the Appellant's foot structure or function. [Doctor 1], in his report dated December 13, 1999, recommended that the Appellant cease using the orthotics that she had previously used, because they were "relatively contraindicated" for her.

[Doctor 9], in his report dated October 8, 2002, commented on the Appellant's use of orthotics: "[Appellant] obtained custom foot orthotics in late 1998, as treatment for her lower back and left hip pain […]. To the extent foot orthotics were indicated for this purpose, changes in foot posture 3 years later, necessitating new custom orthotics would not have been anticipated."

Based on the weight of the evidence, we find that the Appellant has not established, on a balance of probabilities, that she suffered any right foot altered structure/dysfunction due to the Second MVA. As result, we find that the Appellant has not established, on a balance of probabilities, that she is entitled to a PI benefit for this condition.

PI #17: Bladder Irritability

[Doctor 3], in his December 17, 2002, report, noted that following the Fourth MVA, the Appellant "was also noting chronic ongoing bladder irritability, which was much worse after this accident." [Doctor 3] did not indicate that the Appellant's bladder issues were caused by the Fourth MVA; rather, his comments would suggest that they predated it. There are no reports from the Appellant's health care providers indicating that she has a bladder condition caused by the MVAs.

[Doctor 9], in his report dated October 25, 2002, opined that medical information had not been submitted which established a probable causal relationship between bladder symptoms and the MVAs that the Appellant had been involved in.

Based on all of the evidence, we find that the Appellant has not established, on a balance of probabilities, that she suffered a bladder condition caused by the MVAs. As a result, we find that she has not established, on a balance of probabilities, that she is entitled to a PI benefit for this condition.

PI #18 – PI #21: Segmental Dysfunction of the Spine OA/AA, C2-3, L2-3 and L3-4

The Appellant is seeking PI benefits for segmental dysfunction of certain areas of her cervical spine and lumbar spine arising from the Fourth MVA. We reviewed the documentary medical evidence, and note that this condition appears to be mentioned by only one of the Appellant's health care providers, her physiotherapist [Physiotherapist 3]. In his report to MPIC dated October 8, 2002, he noted that he began treating the Appellant on June 27, 2002, which was three months after the Third MVA. He described that on observation, he noted "segmental movement dysfunction at the L3 L4 level". He then saw the Appellant on September 16, 2002, three days after the Fourth MVA. In his report documenting that visit, dated October 15, 2002, he noted, among other things, signs of "segmental dysfunction OA/AA and C2 C3" as well as "segmental dysfunction L2 L3". He provided a supplemental report to MPIC dated October 28, 2002, which listed the various treatments administered to the Appellant up until the Fourth MVA, including "active mobilization segmental dysfunction L3 L4". However, [text deleted] did not provide any further comments regarding the findings that he made in his October 15, 2002, report. There is no evidence that [Physiotherapist 3] referred the Appellant for further medical assessment in respect of his findings of segmental dysfunction of her cervical or lumbar spine.

The Appellant testified regarding the pain that she had in her cervical and lumbar spines, and the continuing difficulty that these areas cause her. However, there is no medical evidence before us that establishes that her pain is attributable to any segmental dysfunction in those areas.

We note, in fact, that there is a paucity of medical evidence regarding this condition. Apart from the reports of [Physiotherapist 3], the only other comments on this condition are from [Doctor 10]. In her report dated July 14, 2017, she noted that segmental dysfunction is a "clinical diagnosis", and that it is "is a term used by treating practitioners to describe subjective misalignment of the vertebrae". She went on to state that the analogous provision proposed by the Appellant for a PI benefit award would not be applicable, because that provision requires documented radiographic evidence of vertebral change, which is not the case here. [Doctor 10] reiterated that view in her report of December 14, 2018. We note, however, that before a consideration of the applicable PI benefit provision is undertaken, the Appellant must establish an entitlement to the PI benefit.

Here, as noted above, the only evidence regarding this condition is from one health care practitioner. While [Physiotherapist 3] noted signs of segmental movement dysfunction at the L3 L4 level three months following the Third MVA, he did not comment that any diagnosis was caused by the Third MVA. Similarly, while he noted signs of segmental dysfunction OA/AA and C2 C3 as well as segmental dysfunction L2 L3 three days following the Fourth MVA, he did not comment that any diagnosis was caused by that MVA.

Weighing all of the evidence, we find that the Appellant has not established, on a balance of probabilities, that any diagnosis of segmental dysfunction of her OA/AA, C2-3, L2-3, or L3-4 vertebrae was caused by any of the MVAs; even if she had, we find that the Appellant has not established, on a balance of probabilities, that this condition was an impairment, or that it was

permanent. Accordingly, we find that the Appellant has not established, on a balance of probabilities, that she is entitled to a PI benefit for this condition.

PI #22 & PI #23: Enhancement Factors – SI Joint Instability, Shoulder Girdle Dysfunction

As indicated above, we have found that the Appellant has failed to establish that either of her SI joints suffered from a permanent impairment, or that she is entitled to any PI benefits in respect of left or right SI joint instability. As a result, we find that the Appellant has not established, on a balance of probabilities, any entitlement to an enhancement under section 2 of the PI Regulation in respect of those conditions.

Similarly, as indicated above, we have found that the Appellant has failed to establish that either of her shoulders suffered from a permanent impairment, or that she is entitled to any PI benefits in respect of bilateral shoulder girdle dysfunction. As a result, we find that the Appellant has not established, on a balance of probabilities, any entitlement to an enhancement under section 2 of the PI Regulation in respect of that condition.

Conclusion

In summary, after a careful review of all the reports and documentary evidence filed in connection with this appeal and after careful consideration of the testimony of the Appellant and of the submissions of counsel for the Appellant and counsel for MPIC and taking into account the provisions of the relevant legislation, the panel finds as follows:

1. that the Appellant has met the onus to establish, on a balance of probabilities, that she is entitled to a permanent impairment benefit in respect of her osteitis pubis.
2. that the Appellant has not met the onus to establish, on a balance of probabilities, that she is entitled to any other additional permanent impairment benefits (other than in respect of

her osteitis pubis), and that the Appellant's permanent impairment benefits were otherwise correctly assessed and calculated.

**Disposition:**

Accordingly, the Appellant's appeal is allowed to the limited extent indicated above and herein. The decision of the Internal Review Officer dated January 14, 2013, is:

1. Varied, to provide that the Appellant is entitled to a permanent impairment benefit in respect of her osteitis pubis; and
2. Upheld, with respect to the assessment and calculation of all of the Appellant's other permanent impairment benefits.

The matter is hereby returned to MPIC's case manager, for a determination as to the appropriate amount of the PI benefit to be awarded to the Appellant for osteitis pubis pursuant to subsection 129(2) of the MPIC Act.

The Appellant shall be entitled to interest upon the monies due to her by reason of the foregoing decision, in accordance with section 163 of the MPIC Act.

The Commission shall retain jurisdiction in this matter and if the parties are unable to agree on the amount of compensation, either party may refer this issue back to the Commission for final determination.

Dated at Winnipeg this 11th day of December, 2020.

**JACQUELINE FREEDMAN**

**LAURA DIAMOND**

**LINDA NEWTON**