WORKPLACE SAFETY AND INSURANCE APPEALS TRIBUNAL

DECISION NO. 299/07

BEFORE:	A.G. Baker : Vice-Chair B. Wheeler : Member Representative of Employers F. Jackson : Member Representative of Workers
HEARING:	February 6, 2007, September 4, 2008, November 17, 2009 at Toronto Oral
DATE OF DECISION:	November 26, 2010
NEUTRAL CITATION:	2010 ONWSIAT 2708
DECISION(S) UNDER APPEAL:	WSIB Appeals Resolution Officer (ARO) decision dated September 12, 2004

APPEARANCES:

For the worker:	J. Lamont, Paralegal
For the employer:	Not Participating
Interpreter:	n/a

REASONS

(i) Introduction to the appeal proceedings

[1] The worker appeals the decision of Appeals Resolution Officer (ARO) N. Kissoore, dated September 12, 2004. In that decision, the ARO ruled that the worker was not entitled to Non-Economic Loss (NEL) awards for the neck or left shoulder. The worker was also denied entitlement to Psychotraumatic Disability and entitlement to ongoing Loss of Earnings (LOE) benefits from November 26, 2002.

(ii) Issues

1. Entitlement to a NEL award for the neck and left shoulder.
2. Entitlement for Psychotraumatic Disability (PD) benefits.
3. Entitlement to LOE benefits beyond November 26, 2002.

(iii) Background

[2] The worker was a cosmetician at a drug store on November 6, 2002. She was standing on a step stool when a customer bumped her with a shopping cart. She fell towards the customer and twisted her upper body, and felt pain in her left shoulder and neck. The record indicated she was on modified duties for a week then returned to regular duties. She stopped working on November 26, 2002, claiming that she was totally disabled.

[3] The worker based her disability on a number of medical conditions, which included depression. While there were some discrepancies as to the date of onset, depression was indicated to be the primary disabling condition as was stated in her application form for private insurance sickness benefits. Additional conditions were also indicated, including shoulder pain, diverticulitis, and variable blood pressure.

[4] The worker was denied entitlement to benefits on the basis that depression was the primary cause of the worker's disability, and unrelated to the accident or its sequelae. A permanent impairment claim for the neck and left shoulder were also denied due to a lack of medical evidence. Loss of earnings (LOE) benefits were also denied beyond November 26, 2002, on the basis that the LOE was unrelated to the worker's neck or left shoulder strain, which was found to have resolved by November 13, 2002.

[5] The worker testified she came to Canada from Bosnia in 1992. She studied English and had a young daughter. She stated she had previously worked in the government in Bosnia. She also studied and began working towards becoming a social worker or cosmetician. She stated she was healthy when she came to Canada. She also worked in retail with facial makeup at several places.

[6] The worker testified she joined the employer in 1998 as a permanent full-time cosmetician in downtown Toronto. She found it physically and mentally hard work in a busy location, but did not have any problems at work. She was at one location for four years, then asked to move closer to her home. She moved to a large store that was not as busy, but she

stated she was happy to be closer to home. Although she also noted that a new manager was alleged to cause problems for the worker.

[7] The worker stated she did not have an accident until November 6, 2002, and that the November 1 date was an error on her private claim forms. She stated that she had been moving boxes for the holidays and was on a ladder when she was pushed by the shopping cart. The worker described falling toward the customer when she felt a crack in her back and neck. She also stated she tried to avoid landing on the customer. She finished her shift and returned to work the next day, but ended up asking a co-worker for a drive home.

[8] The worker stated she attended a walk-in clinic and was subsequently prescribed Vioxx and to she was not to use her left hand. Modified work was recommended and a note given to the worker's manager. She stated though that she returned to her regular job, but could not recall if she was assisted by anyone. The worker also attended a number of doctors for various problems including pain, increased blood pressure, her neck and shoulder, and psychological difficulties. She also noted having been treated for a thyroid problem and seeing a cardiologist, as well as other difficulties.

[9] The worker also stated she had some problems with her new manager and that the manager had tried to make her look bad in front of her co-workers. She described several incidents on her last day at work on November 26, 2002. They included missing shoes, and knives left out on a table crossed, which reminded her of the war in Bosnia. She stated she was healthy before she came to the new location, but stated she was upset by these incidents. She recalled setting off the security alarm when a tag was placed on her coat. She stated she became very upset, vomited, and continued to be sick for some time. She also suspected something had been put in her tea.

[10] The worker did not return to work after November 26, 2002. She asked without success to return to her previous location. She stated she became very depressed and also had anxiety. She began to see a psychiatrist, which she stated had not occurred before. She stated she continues to be treated by her family doctor and her psychiatrist. She takes medication for her conditions. She does not think she is capable of returning to work. She described her average day as suffering with a lack of sleep, doing very little, being in pain, and requiring help from her daughter and husband for tasks such as grocery shopping. She described going to church but does no real housework, and does not really watch television. She stated she walks outside a little in the summer.

(iv) Law and policy

[11] In this case, the *Workplace Safety and Insurance Act (*WSIA*)* applies. I also note Board *Operational Policy Manual* (OPM) Document No. 18-03-02, which states that a worker who suffers a loss of earnings as a result of a work-related injury is entitled to payment of loss of earnings (LOE) benefits. Further, if a worker's injury results in permanent impairment, the worker is entitled to compensation for non-economic loss. Permanent impairment means impairment that continues to exist after a worker reaches maximum medical recovery (MMR). Under Board OPM Document No.11-01-05, MMR is reached by a worker when it is not likely that there will be any further significant improvement in their medical condition.

[12] Under OPM Document No.11-01-15, a worker who has a pre-accident impairment and suffers a minor work-related injury or illness to the same body part or system is entitled to benefits on an aggravation basis. The policy also provides that a worker may be entitled to a NEL benefit if she suffered a permanent impairment as a result of an aggravation.

[13] A worker may also be entitled to benefits if it is evident that a diagnosis of psychotraumatic impairment is attributable to a work-related injury or a condition resulting from a work-related injury. Board OPM Document No. 15-04-02 refers to Psychotraumatic Disability in the following terms:

> **Policy**
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> A worker is entitled to benefits when disability/impairment results from a work-related personal injury by accident Disability/impairment includes both physical and emotional disability/impairment.
>
> **Guidelines**
>
> **General rule**
>
> If it is evident that a diagnosis of a psychotraumatic disability/impairment is attributable to a work-related injury or a condition resulting from a work-related injury, entitlement is granted providing the psychotraumatic disability/impairment became manifest within 5 years of the injury, or within 5 years of the last surgical procedure.
>
> Psychotraumatic disability/impairment is considered to be a temporary condition. Only in exceptional circumstances is this type of disability/impairment accepted as a permanent condition.
>
> Psychotraumatic disability/impairment resulting from organic brain damage is assessed as a permanent disability/impairment.
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> **Psychotraumatic disability entitlement**
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> Entitlement for psychotraumatic disability may be established when the following circumstances exist or develop
>
> - Organic brain syndrome secondary to
>   - traumatic head injury
>   - toxic chemicals including gases
>   - hypoxic conditions, or
>   - conditions related to decompression sickness.
>
> - As an indirect result of a physical injury
>   - emotional reaction to the accident or injury
>   - severe physical disability/impairment, or
>   - reaction to the treatment process.
>
> - The psychotraumatic disability is shown to be related to extended disablement and to non-medical, socioeconomic factors, the majority of which can be directly related to the work-related injury.

(v) Decision

[14] The Panel reviewed the submissions of the worker's representative dated February 10, 2010. The Panel also noted a number of medical documents that were cited by the ARO as follows:

In looking at the available evidence, I note that following the original twisting injury to her left shoulder and neck, the worker was treated by Dr. A. Toma at the Full Care MD Clinic/Richview. This doctor notes on the Form 8 dated November 7, 2002 that the worker was treated that day with complaints of left shoulder and neck pain. No diagnosis was given other than pain and the doctor recommended a return to modified work for one week (completing a Functional Abilities Form).

The worker returned to employment within the modifications suggested by Dr. Toma and as per the multiple statements on file from coworkers, the employer did provide assistance in the form of coworkers. Following the one week of modified employment, there is no indication that [The worker] required any further assistance nor is there any medical evidence that she continued to receive ongoing medical treatment for her left shoulder and/or neck.

The next indication of the worker suffering any ongoing shoulder or neck pain is the Physician's Report of Re-Opened Claim which was completed by Dr. L. Miladinovic and dated April 9, 2003. The doctor noted the diagnosis as left shoulder bursitis and severe depression. The doctor noted that the worker had decreased range of motion with decreased abduction and flexion. The doctor does not indicate that he treated the worker between November 7, 2002 and April 9, 2003. There is therefore a lack of continuity of medical attention for the left shoulder/neck disabilities.

The sickness and accident form for Canada Life was completed by the same physician. On this form, the doctor noted that the symptoms of depression first appeared on or about November 1, 2002 and resulted in time off work from November 26, 2002. It was noted that the worker was referred to a psychiatrist, Dr. Krstich for the primary condition of "depression". The report also notes additional conditions of complaints as shoulder pain, diverticulitis, variable blood pressure.

The diagnosis of the disabling condition was diverticulitis.

The medical report of the psychiatrist, Dr. Krstich, notes that the worker was referred and seen in assessment on December 6, 2002. The onset was related to "tried to set her up". The report goes on to provide details of circumstances where the worker felt that her manager was not supportive.

This report makes no mention of any complaints or disability with the neck/left shoulder. The doctor noted that he would continue to treat her every two weeks to help her deal with her depression, losses and fear.

A handwritten note of Dr. Krstich dated January 10, 2003 noted that the worker was seen and assessed and suffering from depression and other medical problems and was unable to return to work.

A completed progress report for Canada Life by Dr. Krstich dated February 20, 2003 noted the worker was still being treated for depression with no indication of any other ongoing medical conditions affecting the neck or left shoulder.

A Chiropractor's First Report of July 28, 2003 noted that the worker was referred for cervicogenic spine strain with headaches and rotator cuff sprain along with depression.

A medical report provided at the hearing by Dr. R. Baruch notes that the worker was reviewed and the primary nature of the disability was related to the relationship issues with her manager at the [the employer]. The conclusion of Dr. Baruch was that of a major depressive disorder with an anxiety disorder, post-traumatic stress disorder and delusional disorder. The doctor does note that the worker is experiencing chronic pain in

> her neck and left shoulder which relates to a lifting and twisting injury which she suffered at work. In the body of the report on page 8, Dr. Baruch noted: "In my clinical opinion, [the worker] is experiencing paranoid symptomatology and delusional thinking. This may be part of a delusional disorder or perhaps psychotic depression..." The doctor concluded that it was unrealistic that she will be able to return to the particular [employer] location given the suspicious thoughts that she has as well as her negative experience at that location.

[15] The ARO did not find the worker to have been eligible for continuing benefits for either her organic or psychiatric difficulties. We noted the finding by the ARO that there was a lack of continuity. In that regard, we noted the memorandum on February 12, 2003, by the Claims Adjudicator, who noted that the worker had ongoing difficulties with returning to work since November 26, 2002. The worker had indicated she was also following up with her doctor for her left shoulder/neck, with complaints at the time of stress, high blood pressure, neck/left shoulder, back, and stomach problems. An August 2003 worker's continuity report was consistent with the noted neck/shoulder complaints, with a number of restrictions and psychological difficulties also noted. It was evident from the worker's testimony and the record of her complaint that she continued to have left shoulder/neck problems many months after the accident, as well as sleep and concentration problems.

[16] We also noted the Claims Adjudicator memorandum of May 16, 2003. A call was made to Dr. Miladinovic, who confirmed that the worker had been her patient since January 2003 and was seen in March and April 2003. The doctor confirmed the worker's psychological difficulties and stated that the worker continued to be partially disabled in the left shoulder, and would need left arm restrictions and physiotherapy.

[17] The Panel also noted that, despite ongoing complaints, there was no apparent referral to a Board Medical Consultant for the shoulder and neck. It was also stated that the initial complaint of psychiatric difficulties pre-dated the accident. However, after reviewing the documentation, we did not see any specific date that supported that finding. While the November 1, 2002 date was stated on one private insurance form, there was no treatment record to support that date. We also noted the worker had indicated that date was wrong, and we were persuaded that there was no supported record of her organic conditions pre-dating her work accident.

[18] We also noted that the worker had a number of other medical issues and records of treatment prior to her leaving the employer. However, it was also evident that none of those prior conditions had caused the worker physical or psychological restrictions that kept her from performing her regular duties.

[19] The Panel also noted the shoulder pain diagnosis was part of the bases of the worker's claim for private insurance benefits in 2003. We also noted ongoing problems extending into 2005, from Dr. Lin's neurology report. The worker was found to have had continuing pain down the left arm into her hand. The worker was noted to have significant left arm pain and "significant decreased passive and active range of movement in the left shoulder…" A further neurology report in August 2007 from Dr. Dimitrakoudis, stated the worker had "chronic cervical pain with radiation into both arms…" There were also a number of clinical notations from 2003 to 2007 on the record, with entries at various times for ongoing neck and shoulder pain.

[20] In our view, the clinical record, medical reports and claim information on file provide what we found to be continuity and compatibility between the worker's accident and her chronic neck and left shoulder difficulties. It was evident that from the initial accident, there was no significant gap in seeking treatment and the worker clearly continued to see her family doctor, specialists, and attended physiotherapy. It was evident that the worker's neck and shoulder injuries did not fully resolve and were a significant reason she did not return to the workplace. Therefore, in this case, we were persuaded that the worker has permanent neck and left shoulder impairments and is entitled to NEL assessments for those conditions.

[21] In regard to the worker's psychiatric claim, the Panel noted the record of the worker's psychiatric treatment. That included the clinical record and reporting from Dr. Krstich, who treated the worker regularly for a number of years following her work injury. For the bulk of the time, the worker was attending the doctor every two to four weeks. It was evident the worker had other difficulties, and her chronic pain was cited as part of the basis of the development of psychiatric difficulties. The doctor's October 2007 report confirmed the record of treatment and cited the worker's constant pain in the "left shoulder, neck and shoulder blade."

[22] It was also noted from a previous report of Dr. Krstich in March of 2004, that the worker had attended the doctor every two weeks since December 6, 2002. Further, that the worker's depression had become chronic. The doctor also specifically related the worker's symptoms of depression to work circumstances. The Panel also noted the above cited report from Dr. Baruch. Given that opinion, the Panel ruled that an assessment through the Tribunal's Medical Liaison Office would be sought.

[23] The MLO assessor, Dr. Margulies, psychiatrist, provided an in depth report in July 2009. The worker's background was reviewed and the work accident noted. The doctor also noted the course of the worker's treatment with various medications and physical therapy, as well as her ongoing neck and shoulder conditions. The doctor also noted the worker having ongoing emotional distress she attributed to her chronic pain. The conflict with her manager and the alleged harassing work incidents were also noted. Dr. Margulies also opined in part as follows:

> On the basis of the history provided by [the worker], and assuming its accuracy, she would appear not to have had any vulnerabilities or predisposition towards mental illness and would appear to have been capable of sustained relationships and regular work, both hallmarks of positive mental health. However, noteworthy in the provided pre-accident records is what appears to be a repetitive pattern of somatic complaints (e.g. chest pain, visual disturbance, muscular weakness) without demonstrable physical pathology and, therefore, suggestive of a propensity to somatization - multiple somatic complaints which cannot fully be explained by any known general medical condition – and therefore of some form of somatoform disorder. While there is, however, insufficient data to confirm this impression, there is much in [the worker]'s past history, limited as it may be, in support of such and, therefore, suggestive of possible unresolved emotional conflict or need.
>
> On November 6, 2002, while at work [the worker] was reportedly knocked off a small step stool and was rendered immediately symptomatic with pain in her neck and right shoulder. She apparently lost no immediate time from work, was supported in modified duties for the first week, and continued regularly to work until November 26, 2002. On that day, she apparently developed severe gastrointestinal symptoms of nausea, vomiting, diarrhoea and abdominal pain which clearly were the immediate symptoms which led to

her cessation of work at that time. Notwithstanding medical documentation that she had experienced an episode of acute diverticulitis from which she had suffered before, [the worker] interpreted the development of her symptoms in a malevolent light: that someone had intentionally put something into her tea, that, in effect, she had been poisoned. It is extremely unlikely that this was the case and far more probable that her conclusion was false and that her belief and her explanation of what happened, a belief which has not changed into the present, was in the nature of a paranoid delusion. Even prior to the incident of November 26, 2002, [the worker] had earlier experienced many delusional misbeliefs, starting when she began work at her most recent location, in October, 2002, if not before. Her suspicions that she was not wanted and was not welcome in the store, and was ignored by both her manager and co-workers, and was chosen to be harassed, all are representative of paranoid delusions. Her seeing particular significance in two "crossed" knives left in the staff room and their subsequent disappearance from it, is an idea of reference. Taken together, both paranoid delusions and ideas of reference very much point to the diagnosis of a delusional disorder. That [The worker], some six and a half years later, has still maintained her suspicious beliefs is an indication of the persistence of this delusional disorder. Not uncommonly, a dysphoric mood is frequently associated with individuals experiencing a delusional disorder and represents the person's emotional reaction to what, to him or her, are alarming circumstances. In other words, likely since at least the time she began to work in her most recent location, and likely even before it, [The worker] was experiencing a delusional disorder. By reason of its very nature, fixed and false, she was convinced of the accuracy of her misbeliefs and reacted to them with feelings of much sadness and irritability. Based upon this examination, while it is difficult to determine whether her reaction of a dysphoric (or depressed) mood reached proportions to fulfil diagnostic criteria of a major depressive disorder, the fundamental pathology was in the nature of a delusional disorder. This was already developed prior to November 6, 2002 when she was involved in her work-related accident.

It is not clear at what point [the worker] may have developed depressive symptoms but, far more likely than not, they antedated her work-related accident and were exacerbated with her delusional conviction that she had been, in effect, poisoned (on November 26, 2002). It is extremely unlikely that what pain she continued to experience following the accident of November 6, 2002 had, within one month, led to her developing a major depressive disorder and to her coming under psychiatric care. The time frame, of a depressive illness developing in conjunction with persisting chronic pain, is far too short and an individual would not be expected to be so sufficiently demoralized that within one month he or she would have developed a major depressive disorder. In this regard, further information leading to the circumstances of her initial attendance upon Dr. Krstich for psychiatric consultation on December 6, 2002, would be important to determine.

At this point, [the worker] has identified two major factors for her persisting inability to work: (1) "chronic pain;" (2) mixed feelings of fear, anger and sadness in relation to the store in which she had worked. Emotional factors have likely played a role in the persistence of her perception of pain in sites initially traumatized in the subject accident, in the form of her inner distress and dysphoria being experienced in terms of physical or somatic symptoms. This, diagnostically, could be deemed a pain disorder with psychological factors (while the role of a general medical condition is outside the scope of this examination and expertise of this assessor). In other words, what emotional pain, primarily in the form of dysphoria, [The worker] has come to experience has found expression in sites initially traumatized in the subject accident, likely as a form of somatoform disorder which may have antedated it.

[24] It was evident from the above report that the worker had pre-existing psychiatric difficulties. As the doctor indicated, the worker likely had a somatoform disorder that pre-dated

her accident. While there may have been some minor exacerbation by the work accidents, it was evident that the injuries and the sequelae from the accident were not significant factors. As the doctor noted, it was simply too short a time frame from accident to onset to causally relate the worker's psychiatric condition to her work accident. That finding was further evident from Dr. Margulies report in answers to several questions posed by the Panel as follows:

> 1. *Differential and preferred diagnosis.*
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> Differential diagnosis is: (a) delusional disorder, (b) major depressive disorder with mood incongruent psychotic features, (c) schizophrenic disorder, (d) pain disorder with psychological factors, (e) somatoform disorder, NOS.
>
> Preferred diagnosis: (a) delusional disorder, (b) pain disorder with psychological factors.
>
> Explanation of choice of preferred diagnosis is noted above.
>
> 2. *Relationship between work-related accident (of November 6, 2002) and delusional disorder and pain disorder with psychological factors.*
>
> There is sufficient evidence to indicate that [The worker] was experiencing a delusional disorder before November 6, 2002, such that there is no relationship between the said accident and this delusional disorder. Reacting with depressive symptomatology, if not a major depressive disorder, to her ongoing delusional misbeliefs, [The worker], at an unconscious level, focused upon sites initially traumatized in the said accident as a means of expressing, in part at least, the emotional pain within her. This occurred against a backdrop of what was likely a long established pattern of somatization (as explained above) such that what trauma [The worker] sustained in the subject accident became a serendipitous focus for the emotional pain associated with her delusional disorder.
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> 3. *Other precipitating factors.*
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> On the basis of this examination and review of file, no predisposing or other precipitating factors can be determined. It is generally recognized that delusional disorder can occur de novo and need not be associated with any prior psychopathology. Frankly, the cause of delusional disorder remains unknown.
>
> 4. *Contribution of psychosocial background.*
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> There is nothing in the psychosocial history, as determined during this examination or as documented, which in any way can be seen as any contributory to [The worker] developing a delusional disorder. There is a considerable likelihood that some form of somatoform disorder antedated the subject accident and contributed to the development of a pain disorder as described above.

[25] While the Panel again acknowledges the reporting from Dr. Krstich, we also note the reporting from both Dr. Baruch and Dr. Margulies, an independent psychiatric expert. It was evident from the balance of the medical information that the worker's condition was not causally related to her work accident or injuries. As Dr. Margulies found, the worker's diagnosis included a number of difficulties, such delusional disorder, major depressive disorder with mood incongruent psychotic features, schizophrenic disorder, somatoform disorder, and a pain disorder. The doctor also clearly stated that there was sufficient evidence to indicate that the

worker was suffering a delusional disorder that pre-existed the work accident/injury. It was therefore the worker's delusional beliefs that led to her depressive disorder, along with a "long established pattern of somatization…"

[26] The Panel also noted particularly the doctor's comment that the trauma experienced in the work accident became a "serendipitous" focus for the worker's emotional pain, which was associated again with the pre-existing delusional disorder. Further, as the doctor noted, "… the cause of delusional disorder remains unknown." Dr. Margulies further noted again that it was likely that the somatoform disorder pre-dated the worker's accident and contributed to the development of a pain disorder.

[27] Given the opinion and expert medical evidence from Dr. Margulies, the Panel was persuaded that the work accident and the worker's permanent impairments were not significant contributing factors to the onset or aggravation of the worker's pre-existing psychiatric condition. It was evident that the rise of such a condition was not likely in the short time that it onset following the accident. We were in this case persuaded that the worker suffered a pre-existing psychological disorder that was the basis for the worker's ongoing psychological difficulties.

[28] In conclusion, the Panel finds that the worker does not have entitlement to Psychotraumatic Disability benefits. The worker does have entitlement to permanent neck and left shoulder impairments and is entitled to NEL assessments for those conditions. The worker is also therefore entitled to benefits beyond November 26, 2002, given the above entitlement to NEL awards. We leave it to the Board to determine the extent and duration of those benefits subsequent to November 26, 2002.

DISPOSITION

[29] The worker's appeal is allowed in part.

[30] The worker is not entitled to Psychotraumatic Disability benefits.

[31] The worker is entitled to benefits for permanent neck and left shoulder impairments, and NEL assessments for those conditions.

[32] The worker is also entitled to benefits beyond November 26, 2002. We leave it to the Board to determine the extent and duration of benefits, subject to the usual rights of appeal.

DATED: November 26, 2010

SIGNED: A.G. Baker, B. Wheeler, F. Jackson