WORKPLACE SAFETY AND INSURANCE APPEALS TRIBUNAL

DECISION NO. 774/12

BEFORE:	M. Crystal	:	Vice-Chair
	B. M. Young	:	Member Representative of Employers
	R. W. Briggs	:	Member Representative of Workers

HEARING: April 18, 2012 at Thunder Bay
Oral
Post-hearing activity completed on July 24, 2013

DATE OF DECISION: November 13, 2013

NEUTRAL CITATION: 2013 ONWSIAT 2398

DECISION UNDER APPEAL: WSIB ARO decision dated October 17, 2002

APPEARANCES:

For the worker: Ms. P. Trush, Office of the Worker Adviser

For the employer: Did not participate

Interpreter: N/A

Workplace Safety and Insurance Appeals Tribunal

505 University Avenue 7th Floor
Toronto ON M5G 2P2

Tribunal d’appel de la sécurité professionnelle et de l’assurance contre les accidents du travail

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REASONS

(i) Introduction

[1] This appeal was heard, in Thunder Bay, on April 18, 2012. The worker appeals the decision of Appeals Resolution Officer (ARO) E. Mroczek, dated October 17, 2002. That decision determined that:

i) The worker is not entitled to benefits for psychotraumatic disability; and

ii) The worker is not entitled to a 100% future economic loss (FEL) award for the period subsequent to June 9, 1999.

[2] The worker appeared and was represented by Ms. Pauline Trush, Office of the Worker Adviser. The employer did not participate in the appeal. The worker testified at the appeal hearing.

[3] As is noted below, the Panel sought further medical information in relation to this appeal from a Tribunal Medical Assessor. Following the delivery of a report by the Assessor, Ms. Trush provided written submissions, dated July 17, 2013, on behalf of the worker.

(ii) The issues on appeal

[4] The issues to be determined in this appeal are:

i) Whether the worker is entitled to benefits for psychotraumatic disability; and

ii) Whether the worker is entitled to a 100% FEL award for the period subsequent to June 9, 1999.

[5] It should be noted that the ARO decision indicated that the worker was not entitled to 100% loss of earnings (LOE) benefits for the period subsequent to June 9, 1999, however, since the date of injury for the accident claim which is the subject of this appeal is April 21, 1995, the *Pre-1997 Act* governs the worker's entitlement to benefits in this appeal. LOE benefits are not available pursuant to that Act, and given that the ARO was considering the worker's entitlement to (to use a more general term) wage loss benefits, it is apparent that the ARO should have considered the worker's entitlement to a FEL award, the appropriate benefit under the applicable legislation. This point was acknowledged in correspondence, dated March 17, 2011, from the Manager, Appeals Branch, to the worker's representative. That letter concluded by stating:

> Although the ARO did not make specific reference to FEL benefits in his decision, it is evident that the decision would include all types of benefits related to wage loss, including FEL benefits…

[6] In the circumstances of this appeal, according to an internal Board memorandum, dated the worker June 2, 1998, the Board determined that the worker's FEL award at initial determination (D1) should be a sustainability FEL award effective from July 1, 1998, together with a supplementary benefits awarded pursuant to section 43(9) of the Act, to September 1, 1998. However, following the enactment of the *Workplace Safety and Insurance Act, 1997,* as of January 1, 1998, a FEL award made in relation to a pre-1998 injury is subject to review "if a material change of circumstances occurs." The worker ceased his employment with the accident

employer on June 9, 1999, and we find that this was a material change in circumstances. Accordingly, we have jurisdiction to review the worker's FEL entitlement, effective from that date.

(iii) The Panel's memo provided to retain a Tribunal Medical Assessor

[7] At the hearing of this appeal, the Panel determined that it wished to put certain questions to a Tribunal Medical Assessor before rendering its final decision in this appeal. With the assistance of the Tribunal's Medical Liaison Office (MLO), the Panel determined that it wished to obtain an expert medical opinion from a Medical Assessor in relation to the worker's appeal. The Panel prepared a memo, dated April 20, 2012, which provided some background information about the circumstances of the appeal, however, our purpose in obtaining a Tribunal Assessor in psychiatry was to obtain more information about the worker's psychiatric diagnosis, if any. Accordingly, we requested that the Assessor undertake an "in-person" assessment of the worker, and provide the Panel with more information about the Assessor's diagnostic impressions of the worker. The memo stated:

> The Panel completed the hearing of evidence in this appeal on Wednesday April 18, 2012. We would like to request that a Tribunal medical assessor in psychiatry be retained to assist the Panel with the disposition of this appeal.
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> The issues in this appeal are:
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> 1. Whether the worker is entitled to benefits for psychotraumatic disability; and
> 2. Whether the worker is entitled to 100% FEL benefits for the period subsequent to June 9, 1999.
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> We are seeking the assistance of the medical assessor, primarily in relation to the first of these issues.
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> The worker was employed as a welder by a manufacturer of rail rolling stock. He testified that he began to experience problems with his back subsequent to an accident that occurred in February 1989, when he was hit in the back by a metal frame. He stated that he was paid benefits by the Board for his lost time, and that he returned to work several months after that accident, although he continued to experience pain in his back after his return to work.
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> The worker testified that he had a further accident on April 21, 1995, when he slipped while carrying steel weighing about 25 lbs, and he reinjured his back. This accident was allowed as a new accident, although the worker maintains that this should have been treated as a recurrence of his prior injury. In any event, it is the accident of April 21, 1995, which is the subject of this appeal, and the issue of whether that accident should have been considered by the Board as a recurrence was not before the Panel. The Board ultimately granted the worker a 30% non-economic loss (NEL) award for the low back injury that resulted from the accident on April 21, 1995.
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> The worker testified that he lost a week or two of time after the April 1995 accident, but that he returned to work subsequently. He stated that he applied for a different position with the employer as a "finisher", and that this employment may have been somewhat more suitable for him in light of his injury, although it required some lifting. He indicated that he sought this position primarily because he liked this type of work, and he wished to obtain the appropriate classification for this work.
>
> The worker stated that he obtained the position of finisher, and performed it for a year or two, but that during this period he continued to have problems with his back. He indicated that periodically he lost time due to his back problems, and that the Board paid him for this lost time.

The worker testified that the employer subsequently provided him with lighter work in "deburring". The worker explained that, in this work, he was required to remove the sharp edge from metal plates that had been cut. Although this work was more suitable in light of the worker's back injury, he continued to experience back pain and lost time. The worker stated that after a number of periods of lost time and attempts to return to work, a meeting was arranged with the employer, himself and the Board's return to work mediator. The worker stated that the outcome of this mediation was that the employer created a new light job for him, which involved inserting rubber fittings on clamps. He stated that the agreement reached with the mediator involved him working graduating hours, increasing his hours over a period of weeks, until he returned to his full eight hour shifts.

The worker testified that about five weeks after beginning this new job, when he had increased his hours to about 6 or 7 hours per day, the employer required him to return to deburring, which again caused him to experience back pain.

The worker stated that he worked for a few months performing deburring when, on June 9, 1999, one of the employer's supervisors asked him to perform an emergency job which required him to use a heavy grinder to remove an edge from a large metal plate. The worker stated that he believed that a cutting torch would have been more appropriate for the job than a grinder. In any event, he testified that this job would require him to lift the metal plate, which weighed more than 30 lb., which was beyond his medical restrictions. He indicated that the heavy grinder which was to be used weighed about 60 lb., again beyond his accepted restrictions. The worker stated that he initially refused to perform the work, but that the supervisor told him either to perform the work or go home. The worker indicated that he tried to perform the work, using a smaller grinder, which weighed only a few lb., but which was not adequate to perform the job.

The worker testified that he tried to perform this work on June 9, 1999 for five to ten minutes, after which he took a break. He stated that he worked for another short time, and took another break. He stated that after a few attempts to do the work, he experienced a severe episode of back pain and he dropped the grinder. The worker testified that a co-worker realized he was in distress and his foreman was called to address the situation. The worker stated that the foreman asked him if he wanted to have an ambulance called for him, but he indicated that he wanted to go outside to stretch, to see if he could improve his pain in this manner. The worker stated that he subsequently decided to go home and he told his foreman that he was leaving the work site.

The worker testified that when he got home, he took a hot bath, and some pain medication. He stated that he saw his family doctor the next day, and that his doctor told him not to return to work. June 9, 1999 was the last day that the worker performed work for the accident employer.

The worker testified that this incident on June 9, 1999 was emotionally stressful for him and that he subsequently became depressed, primarily due to his pain and his inability to continue working due to the pain. He stated that he was prescribed anti-depressant medication by his family physician, and that subsequently, he received treatment for his psychological condition. The case materials provide further information about the worker's further psychiatric treatment. We expect that the medical assessor who is retained to assist with the appeal will review this medical information and that a summary of the information will not assist the assessor.

At the hearing, the worker testified that he had stopped taking anti-depressant medication because it caused gastro-intestinal distress. At the hearing, he stated that, at the time of the hearing, he had not seen his family physician for more than one year, and that he had not had any recent psychiatric or psychological treatment.

There was some evidence in the case materials that the worker had been diagnosed with depression, and that this was attributable to chronic pain. For example, a report, dated

August 26, 2006, prepared by Dr. Emily Dy Pac, psychiatrist, stated that the worker "suffers from depression for the past 10 years" and that "the depression is tied to the advanced chronic back pain that he suffers from." (see Addendum No. 5, page 17)

There is other medical information on file, however, which is not consistent with this finding. For example, a report, dated December 10, 2008, prepared by Dr. Kyle Hampe, psychiatrist, stated that the worker "did not appear depressed and denied suicidal ideation" and later in the report that "he is not depressed" and "the patient is not psychotic." (see Addendum No. 5, page 10 -11) We also note that the Case Record includes a report, prepared by Dr. G. Bartolucci, psychiatrist, dated April 11, 2001, which stated that "there is no reason for this man to be on a psychiatric unit", although the report refers to the worker's reports of depression .

Noting that there is inconsistent medical information about the worker's psychiatric status, we require that the Tribunal's assessor in psychiatry conduct an in person "face to face" psychiatric examination of the worker and to provide us with a medical information in relation to his clinical psychiatric condition. In particular, we would like the assessor to provide answers to the following questions:

- Does the worker have a diagnosis of a clinical psychiatric condition? If so, please provide your DSM-IV multi-axial diagnosis of the worker, including differential diagnoses, if applicable.
- As of the time of your examination of the worker, is it your opinion that the worker suffers from clinical depression? If so, please explain the causal factors which you believe have contributed significantly to his depression.

Please refer this memo to the Tribunal's Medical Liaison Office to determine whether they believe these questions are appropriate, and whether there might be other questions which should be posed to the assessor.

At the hearing, the worker agreed to being examined by a Tribunal assessor in psychiatry. Please obtain the necessary written consents after the assessor has been identified.

Finally, at the hearing, the worker's representative, Ms. Pauline Trush, Office of the Worker Adviser, indicated that she would seek to obtain further psychiatric medical information, which may not have been included in the case materials. Please have a member of TCO follow up with Ms. Trush in order to obtain any further outstanding psychiatric medical information concerning the worker, which might be available.

The Panel does not intend to release an interim decision making further findings of fact. We are primarily interested in obtaining a current psychiatric diagnosis of the worker from a medical assessor in psychiatry.

Thanks in advance for your assistance in this matter.

(iv) Medical opinion from the Tribunal Medical Assessor, Dr. A. I. Margulies, psychiatrist

[8] As noted above, in order to assist us in addressing the issues in this appeal, the Panel sought the assistance of a Tribunal Medical Assessor. A medical report, dated March 21, 2013, was requested and obtained from Dr. A. I. Margulies, psychiatrist, who was retained as the Tribunal Medical Assessor for this appeal. The report provided answers to the questions posed by the Panel in relation to the appeal, which were set out in correspondence, dated February 4, 2013, from the Tribunal to Dr. Margulies. That correspondence set out the questions, as follows:

1) An opinion based on the findings of fact as noted in the Memorandum, a review of the case materials and a current psychiatric examination;

> 2) Succinct answers to several key questions:
>
> 1. Does the worker have a diagnosis of a clinical psychiatric condition? If so, please provide your DSM-IV multi-axial diagnosis of the worker, including differential diagnoses, if applicable.
> 2. As of the time of your examination of the worker, is it your opinion that the worker suffers from clinical depression? If so, please explain the causal factors which you believe have contributed significantly to his depression.

[9] Dr. Margulies provided a report, dated February 4, 2013, addressing the issues raised by the questions posed by the Panel. The report is 14 pages long and is summarized and excerpted below.

[10] The report stated that Dr. Margulies met with the worker on February 19, 2013 for a period of three and one half hours, and that he had reviewed the documentation relating to the case provided to him by the Tribunal. Dr. Margulies indicated that, at the time of their meeting, he had never before met the worker and that he had had had no prior personal or professional relationship with him any member of his family.

[11] The report noted that the worker was "fully aware of the nature and purpose of this psychiatric assessment" and that it was being conducted "in the context of an appeal of a WSIB decision with respect to possible psychiatric sequelae of a work-related injury" The report then stated:

> Notwithstanding his acknowledged understanding, he was dismissive of this examination and of the report to be prepared and was insistent that the whole issue was no longer important to him…

[12] The report went on to describe the worker's history of accidents and associated lost time. It noted that the worker indicated that his initial back injury occurred in 1982 (there may have been some confusion concerning the date of the worker's initial back injury; at the hearing, the worker indicated that the initial back injury occurred in 1989), and that he was off work for "a number of weeks" following the injury. The report went on to indicate that following the 1982 (1989 ?) accident, the worker experienced intermittent flare-ups of back pain, with associated lost time from work, and that he was rarely pain free. He reported a further accident on April 21, 1995, and this is the accident in relation to the claim which is the subject of this appeal. The report indicated:

> …After this incident, which was deemed a new accident and not a recurrence of prior injury, he was away from work for a couple of weeks and thereafter he, typically, continued to experience variable pain in his lower and mid back which was said to have been repeatedly exacerbated by work incidents and to have resulted in what amounted to increasingly longer periods of apparent disability. He also reported experiencing widespread and variable pain and variable numbness and paresthesias in sites not previously traumatized. It is the psychological sequelae of this accident which is the object of [the worker's] appeal and of this examination.

[13] The report went on to indicate that the worker subsequently saw several physicians to treat his ongoing back problems including "Dr. C.J. Cormier, and since 1996, …Dr. H.A. Noetzel, and … a number of specialists, including Dr. M.J. McCormick, orthopaedist, and Dr. P. Rao, physiatrist." The report stated that the worker also undertook physiotherapy treatment and took analgesic and anti-inflammatory medications to treat his pain. It noted that, although the worker had been provided with lighter modified work "he still

reportedly experienced numerous exacerbations said to be work- related and which led to increasingly longer periods of time off work."

[14] The report then discussed the incident on June 9, 1999, which is central to this appeal, and which is described in the Panel's memo, reproduced above. The worker indicated to Dr. Margulies that, as a result of this incident, he sustained "another so-called 'back attack'" which produced acute pain in his lower and mid back, and that he has not returned to work since that incident. The report noted that, since that incident the worker has also reported pain "in many areas of his body which had not been initially traumatized."

[15] Dr. Margulies indicated that the worker advised that the worker "dated the onset of what he called 'depression' to the day he ceased working" and that Dr. Noetzel, his family physician indicated at that time that he was "emotionally run down" and experiencing "depression". The report indicated that the worker was "unable to elaborate upon his emotional state in the days and weeks following his cessation of work" notwithstanding Dr. Margulies' attempts to elicit this information. Dr. Margulies noted that, at this point in their meeting, the worker "spontaneously and without any prior comment or expression or appearance of distress" left the room "to have a smoke" and that when he returned he "apologized for having become 'emotional'". The report stated that the worker then described "losing control of his pain and 'losing his mind'", although, again the worker was not able to elaborate on this. The report commented on the fact that, notwithstanding the worker's comments, his accounts were "relayed in a calm and seemingly unconcerned manner which was incongruent with his subjectively reported distress."

[16] The report went on to state that the worker indicated that he was diagnosed with depression by Dr. Noetzel, immediately after he ceased working, and that Dr. Noetzel prescribed anti-depressants. The worker described his depression as "a sense of pressure on his mind…like a hundred pounds on [his] head… spaced out and seeing blurry" but could not elaborate further. The report also indicated that there was some inconsistency between the worker's account of when he was initially prescribed anti-depressant medication , and that the "clinical records of Dr. Noetzel [indicated] the use of anti-depressant medication starting roughly a year after he ceased work." The report stated:

> While [the worker] reported what amounted to a variable but nonetheless continuous state of what he called "depression" since June of 1999 into the present, and much of the contemporaneous documentation seems uncritically to accept his reports, there is insufficient data in any of the said records which provide a description which is supportive of the presence of the necessary diagnostic criteria of an episode of major depression.

[17] The report went on to refer to the worker's reports of admissions to hospital, due to his emotional state, and in particular an incident in April 2001, when the worker was "threatening to kill himself and had written 'a suicide note'". The report noted that three days prior, the worker had been admitted into a Functional Restoration Program, for which he had been considered an appropriate candidate. Dr. Margulies' report also referred to further hospital admissions in 2006, 2008, and 2010, that the worker indicated were related to depression, suicidal ideation and the worker's assertion that he was "losing his mind". The report indicated that, although the documentation associated with these admissions indicated a diagnosis of "some form of depressive illness", but that "within a very short time after admission [the worker] was generally much improved with little evidence of a depressive illness and soon discharged." In relation to the psychiatric reports generated during these admissions, Dr. Margulies noted:

> …This profusion of opinions clearly reflected a limited understanding of [the worker's] basic characterological structure, much diagnostic confusion, and issues of credibility, all reportedly occurring against a backdrop of severe but variable pain in varying locations. It is to be noted that [the worker's] most recent psychiatric admission in 2010 occurred in the context of then recent marital breakdown under circumstances never made clear but reported to this examiner to have been initiated by him because he felt he was "too much of a burden" to his wife because of his suffering…

[18] The report then referred to the worker's assertion that notwithstanding his "persisting widespread pain" the worker has been "generally able to control [the pain] through 'concentration'", although it remained "unclear to this assessor just what he meant and how he was able to effect such control." The report stated that the worker indicated "he would welcome death as a relief from his pain", but then apparently "contradicting himself, he also reported his ability to enjoy life when, through 'concentration' he can control his pain."

[19] The report went on to focus on the worker's developmental factors and noted that the worker reported significant alcoholism and criminal activity and incarceration associated with his siblings and parents, including the murder of his mother. It also noted that that the worker's first marriage broke down, and that his first wife was promiscuous and had issues with substance abuse. It also noted that he had a son from this marriage with whom "he now has only 'spiritual' communication which somehow or other informs him when his son is 'in trouble'" and that "more traditional communication would appear to be non-existent."

[20] The report also indicated that the worker "failed to reveal, as reported by his wife to one examiner that as long as she had known him – some 20 years – he was prone to 'threatening suicide when under stress'" and that he acknowledged having a criminal record, being incarcerated for theft when he was 15 years old, and "for a number of months for arson when he was 28." The report also indicated that the worker had recently had a heart attack which was treated with a two level stent insertion.

[21] The report went on to analyze the worker's status, and stated:

> [The worker's] subjective complaints and reports as noted by this and other examiners can be divided into two, but by no means unrelated realms: physical/somatic and emotional/psychological. The former, generally speaking, is consistent between examiners and differs little from the findings of fact as noted in Panel's Memorandum, dated April 20, 2012. The latter, which is the subject of this report, has been noted by this and other examiners to be characterized by what amounts to very limited and simplistic descriptions which convey little in terms of his subjective emotional experience and which he sometimes attempted to describe in terms of what would appear to be somatic or physical manifestations of a subjectively disturbing emotionality. At the same time, there was much inconsistency and incongruity between the content of his subjective reports and his objective appearance and behaviour. This pattern is strongly suggestive of what is known as alexithymia, a characterological or personality trait whereby an individual is out of touch with his or her emotions. Such a person is, in effect, emotionally inarticulate and is incapable of verbalizing his or her subjective feeling experiences. Alexithymia is not a psychiatric disorder per se but, rather, a variation of emotional expression that is found in less than 10% of the general population and may be associated with a variety of psychological problems and difficulties. [The worker's] failed attempts to explain what he may have been inwardly feeling and what he called "depression" are, indeed, characteristic of this trait which is longstanding, had nothing to do with and antedated any injuries he may have sustained, and is addressed at this point in order to provide a greater understanding of the inadequacies of [the worker's] attempted descriptions of emotion.

[22] The report went on to discuss the fact that "the reliability of a psychiatric history is critical to a proper understanding of the nature of a person's psychiatric difficulties" and that the worker "at times was a vague, uninformative, seemingly unknowledgeable, and on occasion a slightly confused historian who seemed incapable, by reason of the above noted alexithymic trait, to articulate his feelings" and that "by his very limited use of words and phrases to describe that which was essentially beyond him, [the worker] conveyed a highly variable impression which was ambiguous in its fundamental meaning." The report went on to state that:

> …[The worker's] account came to be uncritically accepted by different observers who supported [the worker's] declaration of "depression" and equated it to a form of depressive disorder when there was very little real clinical basis for doing so. The term "depression" is used to convey different meanings under different circumstances: it may apply to a diagnosis of a so-called clinical depression which can refer to a number of different forms of a depressive disorder; it may apply to an individual's mood at the time; or may apply to an overall feeling tone (affect) which has both subjective as well as objective ramifications. There is nothing to indicate that [the worker's] usage of the term "depression" was ever clarified and much to indicate what amounted to an uncritical acceptance of it to reflect a depressive illness.

[23] The report went on to refer to the worker's "omissions and many incongruities and inconsistencies between what he reported to [Dr. Margulies] and to prior examiners and between his subjective reports and objective observation." It stated:

> For example, [the worker's] description of his early, significant developmental years amounted to one of a major degree of affectional deprivation, parental alcoholism, the premature assumption of a degree of responsibility well beyond his years, a strong anti-authority stance, as well as some criminal activity (which would appear to have been rampant in his family). In contrast, most earlier psychiatric examiners do not appear to have been made aware — whether through lack of inquiry or lack of revelation by [the worker] – of what amounted to a dysfunctional family environment, his many psychopathological traits and by extension the effect upon his personality development…

[24] The report also stated that the worker's "genetic factors as well as the many pathological influences of his earlier years would be expected to have had a significant impact upon [the worker] in terms of relationships, subjective emotionality, self-confidence, propensity to substance abuse and mood disturbance and may, in part, account for his alexithymic trait as a defense against awareness of his profound inner unhappiness and neediness." It also noted that "emotional lability and impulsivity would also not be unexpected and are likely reflected in the reported observation by his wife of his longstanding 'history of threatening suicide when under stress.'" The report went on to state:

> Taking into consideration these various factors noted above along with what information [the worker] revealed to this and to other examiners and relevant collateral information, the impression which emerges is that [the worker] developed into an adult with significant feelings of affectional deprivation, unhappiness, anger, likely unmet emotional needs, impulsivity, a low frustration tolerance and affective instability with marked mood reactivity resulting in intense yet brief periods of dysphoria, suicidal threats or gestures. While there is insufficient longitudinal data to support the diagnosis of a clinically significant personality disorder, there is much to suggest the presence of various pathological personality traits. These characteristics have unquestionably been very longstanding, were apparent in adolescence, have persisted into the present, and have played, in their interaction with the vicissitudes of his life circumstances, a major role in the development of what psychiatric difficulties [the worker] has experienced.

[25] The report noted that "one would have a very high index of suspicion that long before that time [i.e., 2000] [the worker], unable to tolerate, express or even fully recognize or understand what emotional distress he may have experienced, would have had similar episodes of emotional decompensation and affective instability with dysphoria" and that, "while, admittedly, there is no information to support this contention of earlier periods of decompensation, [the worker's] account that he first developed 'depression' on the very day he ceased working, June 9, 1999, and that it was so recognized and treatment immediately instituted by Dr. Noetzel, along with references to use of fluoxetine, cannot be confirmed."

[26] The report concluded by stating:

> On the basis of objective and confirmed observation, there is no information about [the worker's] emotional state in the year following the purported severe "back attack" (of June 9, 1999), [the worker's] subjective reporting being of "severe depression," which he simply attributed to his painful symptoms, which, by 2001, had led to his total demoralization to the point of suicidal threats. Such behaviour, which led to his first psychiatric admission, by his wife's reporting was known to occur long prior to the events of 1999 or 1995 and is consistent with what is known about his fundamental personality structure. In other words, what amounted to a brief period of emotional decompensation – profound dysphoria with threats of suicide and which rapidly resolved within two days — is entirely in keeping with [the worker's] characterological make-up. From a diagnostic perspective, it can best be deemed an adjustment disorder with depressed mood. While he attributed similar episodes to pain which also led to brief psychiatric hospitalizations with rapid symptom resolution, it is documented that his admission of August 26-29, 2006 would appear to have been precipitated by his loss of a number of cats, his attachment to which even surprised him, that of December 7-10, 2008 would appear to have been precipitated by [the worker] being "likely overwhelmed again with his housing situation," while that of July 24-28, 2010 would appear to have been his reaction to recent breakdown of his marriage. Loosely described as "depression" by [the worker], these reactions of acute dysphoria and threatened suicide "when under stress" and more specifically threatened loss remain characteristic of and reflect his basic characterological structure. To the extent that pain may have played a role in his reactions cannot clearly be determined but it is apparent that many factors, (as noted above), other than pain have been sufficient stressors to result in what his wife has indicated to be typical behaviour.
>
> For reasons referenced above with respect to the nature and quality of his significant developmental years of affectional deprivation, unresolved dependency needs, the assumption of maturity beyond his years, [the worker], more likely than not, was chronically unhappy. Lacking the ability to understand, to be aware and to express his feelings, he was, in effect, out of touch with the extent of his inner unhappiness and what amounted to, in all likelihood, a chronic depression, more accurately called a dysthymic disorder. This has been present for many years, has, typically, varied in intensity according to the vicissitudes of [the worker's] life's experiences, part of which has included his experience of back pain as may or may not be related to the work- related accident of April 21, 1995 and its sequelae. [The worker's] reactivity with increased dysthymia and to brief episodic decompensation is not confined to issues of pain, but he has come to believe and/or has wanted to believe that this, indeed, has been the case. While he has so repeatedly attributed in his subjective reporting, the reality is otherwise. In other words, factors related to the subject work-related accident have played some, but by no means an exclusive role in what emotional discomfort and distress he may have experienced over the years but other factors, which he has come to ignore and deny have been equally if not more relevant.
>
> Specific questions, to be succinctly answered, have been posed to this assessor and will be addressed below:

1. Differential and provisional diagnosis:

   The differential diagnosis, based upon available information, is as follows:

   a) dysthymic disorder

   b) adjustment disorder with depressed mood

   c) major depressive disorder, recurrent

   d) pathological personality traits; alexithymia.

   The provision diagnosis, according to DSM-IV multiaxial assessment is as follows:

Axis 1:	300.4 Dysthymic Disorder
	Adjustment Disorder with depressed mood (by history)
Axis II:	pathological Personality Traits
Axis Ill:	Musculoskeletal and soft tissue injury
Axis IV:	Occupational Problems
Axis V:	GAF 55 (current)

2. It has been questioned whether [the worker] "suffers from clinical depression." In order to address this, it is important to note that "clinical depression" is an inexact and non-standard diagnosis, and lacking definition may refer to any of a number of depressive illnesses, although generally speaking it refers, operationally, to major depressive episode. Assuming this to be the appropriate reference, it can then be said that, in this assessor's opinion, [the worker] is not suffering from "clinical depression". Rather, he is experiencing and has for many years experienced a dysthymic disorder which has varied in intensity with time and the vicissitudes of his life's experiences.

   At times he has also experienced an acute adjustment disorder with depressed mood of moderate to severe extent but, typically, short lived and quickly remitting. Factors contributing to the forms of depressive illness which [the worker] is believed to experience have, hopefully, been clearly addressed above. While, symptomatically, symptoms of an adjustment disorder with depressed mood, as experienced by from time to time, have been very similar, on a cross-sectional basis, to an episode of major depression (which diagnosis has been made on a number of occasions), the very brevity of symptoms — a matter of days — is not consistent with an episode of major depression, which is far more longer lasting.

(v) Applicable law and policy

[27] The workplace accident which is the subject of this appeal occurred on April 21, 1995. Accordingly, the worker's entitlement to benefits in this appeal is governed by the *Pre-1997 Act*.

[28] A central issue in this appeal is whether the worker is entitled to benefits for psychotraumatic disability. The Board's policy on such entitlement is included in *Operational Policy Manual* Document No. 15-04-02. That policy document states in part:

> **Policy**
>
> 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.

Psychotraumatic disability entitlement

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 and clearly related to the work-related injury.

…

(vi) Analysis

(a) Entitlement to benefits for psychotraumatic disability

[29] We have reviewed the detailed submissions, dated July 17, 2013, provided by the worker's representative in support of his claim for entitlement to benefits for psychotraumatic disability. It appears that the worker's apparent long standing depression is central to his claim for psychotraumatic disability.

[30] We note that the submissions cite a Discharge Summary, dated August 29, 2006, prepared by Dr. Emily Dy Pac, psychiatrist, at the time of the worker's discharge from hospital on that date. The report indicated that the worker had been admitted to hospital, in relation to an incident when the worker overdosed on Sertraline. According to the report, the worker subsequently stated that he did not intend to attempt suicide, although this apparently had been his wife's concern at the time of his admission.

[31] The report stated that the worker "suffers from depression for the past 10 years" and that "the depression is tied to the advanced chronic pain that he suffers from". In this regard, the report supports the theory advanced in the submission that the pain that the worker experienced in relation to his workplace injury was central to his psychiatric condition, and that on that basis it should be concluded that workplace factors had, at least, made a significant contribution to the worker's psychiatric problems. We note that the Board's policy document, cited above, provides that entitlement for psychotraumatic disability may be allowed if, as an indirect result

of a work injury, the worker's emotional reaction to his work injury contributes significantly to his psychological injury.

[32] We note, however, that according to the report, the worker's explanation for his "grief" which led to the overdose, was related to the fact that a few days earlier, "four kittens and their mother were given up by [the worker] and his wife to Animal Services" and that the worker and his wife chose this course of action because they "were really not their type of cats and they wanted cats that they could hug"and that "they preferred Persian cats." The report went on to refer to the worker's depression, but then stated that "he did not appear to be significantly depressed and was not suicidal."

[33] To summarize, the report indicated that the worker overdosed on anti-depressant medication to control his "grief" over the loss of kittens, which were not really his "type of cats", and that, although he reported being depressed for the previous ten years, upon his mental status examination, he did not appear to be significantly depressed.

[34] As a Panel, we found the worker's documented history of mental illness, and his presentation, in particular, at the hearing, but also as documented in the case materials, to be confounding. As we noted in our memo for the Assessor, a report, dated December 10, 2008, prepared by Dr. Kyle Hampe, psychiatrist, stated that the worker "did not appear depressed" and later stated in the report that "he is not depressed". Similarly in a report, dated April 11, 2001, Dr. G. Bartolucci, psychiatrist, stated that "there is no reason for this man to be on a psychiatric unit", although the report refers to the worker's reports of depression. These apparent inconsistencies within and between the psychiatric reports caused us to have concerns in determining the worker's entitlement to benefits for psychotraumatic disability, similar to those noted at page 153-154 of *Decision No. 915* (7 W.C.A.T.R. 1), one of the Tribunal's leading cases. At that point in the decision, the Panel discusses the issue of "exaggeration" and notes that:

> …The identification of dishonesty in any aspect of a worker's conduct or testimony will give a Panel cause to approach the whole claim – particularly one of this nature—with justified skepticism. And in a case of the nature of a chronic pain case where such skepticism may not find the reassurance of objective medical findings, that skepticism may lead to a rejection of the whole claim on the basis of the panel failing to be satisfied on the issue of genuineness.

[35] Although we do not find that the worker in this case has been consciously dishonest, similar to a "chronic pain case", as referred to in *Decision No. 915,* the subjective nature of the evidence in a claim for psychotraumatic disability, (i.e., the lack of "reassurance" provided by "objective medical findings", which are typically available in a claim for an organic injury) makes the credibility or reliability of the worker's subjective accounts and descriptions of mental illness, both in testimony, and as reflected in histories provided to the worker's physicians over time, a critical factor in assessing the merit of such claims.

[36] This concern that the Panel had about an apparent "disconnect" between the worker's presentation, and the medical information which referred to the worker's mental illness, caused us to retain Dr. Margulies as the Tribunal Assessor for this case. We asked Dr. Margulies to conduct an interview of the worker in person, and to review his psychiatric information on file, to assist in assessing whether the worker's psychiatric issues could be related to his work injuries. We hoped that Dr. Margulies would be able to take an overview of the worker's case, as opposed to the assessments made by other psychiatrists relating to periods of relatively short

duration. In this regard, we have found the report provided by Dr. Margulies to have shed significant light on the worker's case, and we have attributed significant weight to it. We note that the representative's submissions also acknowledged that the report provided by Dr. Margulies is "the most extensive psychiatric report on file."

[37] We have taken into account the statement at page 13 of Dr. Margulies' report, relied upon by the representative, which stated that:

> … factors related to the subject work-related accident have played some, but by no means an exclusive role in what emotional discomfort and distress he may have experienced over the years but other factors, which he has come to ignore and deny have been equally if not more relevant.

[38] The representative has taken the position that this quote from Dr. Margulies' report supports the proposition that the significance of the worker's work accident is apparently "somewhat equal" in weight to non-work related factors, and that on this basis, the Panel should conclude that the worker's work-related accident contributed significantly to his psychiatric illness, giving rise to entitlement to benefits for psychotraumatic disability.

[39] Having carefully reviewed Dr. Margulies' report in detail, however, we are not able to agree, when all of the factors raised by the report are considered as a whole, that we should conclude that the workplace factors contributed significantly to the worker's psychiatric illness.

[40] First, we do not interpret the passage cited above by the representative to mean that it was Dr. Margulies' view that the workplace and non-work related factors contributed about equally to the worker's condition. The portion cited stated that the worker "has come to ignore and deny" the fact that "other factors", (i.e., non-work related factors) "have been equally *if not more relevant* [emphasis added]." We interpret this passage to mean that Dr. Margulies concluded that the worker has denied the significance of non-work related factors as factors affecting his condition. Particularly in light of the content of the balance of the report, we do not consider this passage to mean that Dr. Margulies came to the conclusion that the work-related factors made a significant contribution to the worker's overall psychiatric status. In this regard, we have taken into account the following points raised in Dr. Margulies' report:

- Although the worker understood the reason for his assessment by Dr. Margulies, "he was dismissive of this examination and of the report to be prepared and was insistent that the whole issue was no longer important to him";
- Although the worker dated the onset of his "depression" to the day he ceased working, the worker was not able to elaborate upon his emotional state in the days and weeks following his cessation of work, notwithstanding Dr. Margulies' attempts to elicit this information;
- The worker's presentation at his assessment, was casual and unconcerned, and this was incongruent with the content of his reports of apparent distress;
- The worker had difficulty elaborating on the feelings he experienced at the time of his reported depression ;
- Soon after his admission to hospital in 2001 for depression, (having written a "suicide note"), there was "little evidence of a depressive illness":

- The worker reported that he was able to control his pain through "concentration", which the Panel considers unlikely, if the worker's organic pain was a genuine factor contributing to his psychiatric illness, and which was inconsistent with his statement that he would welcome death as relief from his pain;
- There were many non-work related factors associated with the developmental portion of the worker's life, which one would expect could be factors likely to contribute to the worker's psychological distress, including alcoholism and neglect by his parents, the murder of his mother by his brother, the breakdown of his first marriage, no ongoing relationship (apart from "spiritual" contact) with his son, criminal activity by the worker and his family members, and the worker's incarceration;
- Dr. Margulies' indicated that the worker likely exhibited "alexithymia", a characterological or personality trait, in which the subject is "out of touch with his or her emotions". Dr. Margulies indicated that this trait "had nothing to do with and antedated any injuries he may have sustained", and helped to explain the worker's inability to describe his emotional state;
- The worker at times was a vague, uninformative, seemingly unknowledgeable, and on occasion a slightly confused historian who seemed incapable of articulating his feelings. The worker conveyed a highly variable impression which was ambiguous in its fundamental meaning;
- The worker's accounts of his emotional status became "uncritically accepted" by physicians who "equated it to a form of depressive disorder when there was very little real clinical basis for doing so";
- It did not appear that the worker's earlier psychiatric examiners were aware of "what amounted to a dysfunctional family environment, his many psychopathological traits and by extension the effect upon his personality development";
- The worker "developed into an adult with significant feelings of affectional deprivation, unhappiness, anger, likely unmet emotional needs, impulsivity, a low frustration tolerance and affective instability with marked mood reactivity resulting in intense yet brief periods of dysphoria, suicidal threats or gestures."
  Dr. Margulies indicated that "these characteristics have unquestionably been very longstanding, were apparent in adolescence, have persisted into the present, and have played, in their interaction with the vicissitudes of his life circumstances, a major role in the development of what psychiatric difficulties [the worker] has experienced";
- The worker's behaviour, leading to his first psychiatric admission, was known to have been manifest "long prior to the events of 1999 or 1995 and is consistent with what is known about his fundamental personality structure";
- While it is difficult to clearly determine whether pain played a role in the worker's reactions, it is apparent that many non-work related factors (e.g., housing, factors related to his domestic relationship), were sufficient stressors to result in "what his

wife has indicated to be typical behaviour (i.e., threatened suicide when under stress);

- Factors, which included affectional deprivation, unresolved dependency needs, and the need to assume maturity at too early an age, likely caused the worker to be "chronically unhappy". This likely resulted in the worker's "dysthymic disorder" which Dr. Margulies concluded was the worker's primary Axis I DSM IV diagnosis. Although Dr. Margulies noted that the term "clinical depression" is in fact an inexact term, Dr. Margulies concluded that the worker was not suffering from this condition, which had been indicated in much of the worker's medical information, but rather the more appropriate diagnosis was "dysthymic disorder" which Dr. Margulies indicated "has varied in intensity with time and the vicissitudes of his life's experiences."; and
- The brevity of the symptoms associated with the worker's episodes of depression was "not consistent with an episode of major depression, which is far more longer lasting";

[41] Although we understand that Dr. Margulies' report does not fully rule out the possibility that the worker's pain associated with his work injuries, and in particular, his recurrence in June 1999, contributed to his psychological condition, our reading of the overall report causes us to conclude that such pain was not a significant factor contributing to such condition. Although Dr. Margulies' report refers to worker's pain in some passages, in our view it does not focus on, or emphasize, the worker's pain as a significant factor contributing to his overall psychological condition, at least not to the extent that the report focusses on the worker's characterological and developmental issues or the worker's personality traits.

[42] We note that there are other reports included in the case materials, such as the report provided by Dr. U. Jain, psychiatrist, dated April 28, 2003, which referred to the worker's pain as a factor contributing to the worker's psychological condition, however, as we have indicated above, we attribute greater weight to the report provided by Dr. Margulies, which, as we have indicated, we interpret to mean that non-work related factors contributed to the worker's condition to such an extent so as to overwhelm the significance of the work-related factors, and to make them overall, not significant contributors to the worker's condition. We also note that Dr. Jain's report, dated April 28, 2003, which the representative cited in her submissions, concluded that the worker's need to be in control was "reflective of some of his personality traits" and we interpret that report to acknowledge the worker's personality traits, rather than his work related pain issues, to be the major factor contributing to his psychological distress.

[43] To summarize, we conclude that the worker is not entitled to benefits for psychotraumatic disability on the basis that:

- The report provided by Dr. Margulies indicated that there were a number of significant factors which are not related to the worker's employment, but rather, arise from the worker's life experiences outside of work, which have contributed to his psychological problems. We find that the magnitude of these non-compensable issues overwhelms the significance of the work-related factors, and make the work related factors overall, not significant contributors to the worker's psychological condition;

- Although the report provided by Dr. Margulies stated that the work-related factors "played some role" in the worker's "emotional discomfort and distress", given that the main focus of his report was on the highly significant contribution made by non-work related factors to the worker's psychological condition, we do not interpret the report to mean that the work related factors contributed significantly to the worker's psychological condition; and

- We attribute less weight to the psychiatric information provided by the worker's treating physicians, which indicated that the worker's psychological difficulties were related to, or "tied" to the worker's pain associated with his work injuries. We note that the psychiatrists who treated the worker from time to time, did not appear to emphasize the magnitude of the non-compensable factors which affected his psychological condition throughout his life, and did not present an overall analysis which took all of these factors into account, over time.

[44] On this basis, we conclude that the worker is not entitled to benefits for psychotraumatic disability.

(b) Entitlement to 100% FEL benefits subsequent to June 9, 1999

[45] For the reasons that are provided above, we have found that the worker is not entitled to benefits for psychotraumatic disability. It should be understood, however, that although we have found the worker's psychological distress to be non-compensable, we have not determined that such distress is insignificant. To the contrary, we conclude that the worker has suffered significant psychological problems, and that, according to Dr. Margulies' report, these problems probably preceded the incident on June 9, 1999. In our view, it is likely that the worker's psychological issues are implicated in his inability to return to work after that incident. Because the psychological issues are non-compensable, however, we are unable to take them into account as a basis for allowing FEL benefits subsequent to that date. In our view, the persistence of the worker's non-compensable psychological problems provides a reasonable, if not probable, explanation for his inability to return to work after June 9, 1999.

[46] Because the worker's non-organic factors are not compensable, our analysis turns to his organic factors, and in particular, whether his organic condition can be the basis of ongoing entitlement to a 100% FEL award.

[47] As we have indicated in our memo, dated April 20, 2012, for the Tribunal's Medical Assessor, the worker first injured his back in February 1989, when his back was hit by a metal frame. He sustained further injury to his back on April 21, 1995, when he slipped while carrying steel weighing about 25 lb. As noted above, this is the accident which is the subject of this appeal. The worker testified that he lost a week or two of time after this incident but that he subsequently returned to work. He stated that he had some ongoing back pain, and that, over the next few years, he pursued other positions, such as "finisher" and "deburrer", which were somewhat lighter than his pre-injury work, although they required some lifting, and he lost some time intermittently due to back pain, while carrying out his duties in these positions. According to the case materials, in October 1998, the Board awarded the worker a 30% NEL award for his organic low back injury. We note that notwithstanding this relatively significant award, subsequent to the time that the award was made, the worker continued in his employment with the employer, and was not disabled from working.

[48] As we noted in our memo, after a number of periods of lost time and attempts to return to work while in the deburrer position, a return to work mediation was convened, and a new lighter job was provided to accommodate the worker. The worker testified that the job involved inserting rubber fittings on clamps, and that during the period leading up to June 9, 1999, the date of his occurrence as alleged, and his last day at work, he worked at graduated hours, with the intention of gradually increasing his hours from week to week, until he resumed working his usual eight hour shift. He stated that about five weeks after performing this job, when he was close to resuming full time hours, the employer required him to return to deburring, which again caused him to experience back pain.

[49] The worker stated that he was performing the deburring job on June 9, 1999, the date of the recurrence. He indicated that on that date, one of his supervisors requested that he perform an emergency job that required him to use a heavy grinder which weighed about 60 lb., and to perform heavy lifting. He stated that the job required that he lift a heavy metal plate, which weighed about 30 lb., and that the lifting he was called upon to perform on that date exceeded his restrictions. The worker testified that while performing this work, he experienced severe back pain. He stated that he decided to go outside to stretch, to see if this would reduce his pain, and that he ultimately went home to take a hot bath. The worker stated that he saw his family physician the next day, and that his physician advised him not to return to work. According to the worker's testimony, he became depressed after the incident, and never again returned to gainful employment.

[50] The worker testified that his "depression" was a significant factor in causing him to be unable to return to work. As we have indicated above, with detailed reasons, we have concluded that the worker's psychological distress subsequent to June 9, 1999, does not provide a compensable basis for us to award benefits to the worker after that date.

[51] Considering the medical information that is on file following the incident on June 9, 1999, we note that Dr. Noetzel, the worker's family physician, provided a report, dated June 24, 1999, to the Board, which indicated that the worker was "fairly tender throughout his mid back" and that he had "slightly decreased range of motion". The report stated that the worker's "neurovascular exam that day was intact" and that on June 11, 1999, the worker had been "diagnosed as having a flare up of his chronic back condition on that date." It appears from the report that, in addition to his injury, there may have been employment issues affecting the worker, in that the report stated that the worker was "under the impression that if he couldn't do that work [sic – the deburrer job ?], that his work place was no longer interested in having him in their employ." Dr. Noetzel indicated that he did "not know as a matter of fact, whether this is really true." The report went on to state:

> [The worker] has focused on his back condition for a long time, to a degree that some would probably call obsessive. He keeps daily pain charts and several times a day writes his pain level down, particularly when he has been at work. As well, when he was in the office recently, the prospect of not being employed [with the accident employer] any more didn't seem to be a bother to him.

[52] Dr. Noetzel provided a Physician's Progress Report (Form 26), dated July 9, 1999, which stated that the worker's diagnosis was "flare up thoracic strain" and that the worker was to have restrictions for "no lifting bending, climbing, twisting of back." A further Form 26, prepared by Dr. Noetzel, dated August 27, 1999, stated that the worker's diagnosis was "acute and chronic thoracic and lumbar strain." Similar restrictions were indicated as had been previously, although

the restrictions on this report included no prolonged sitting. We note that these restrictions were indicated to be in place should the worker return to work at the time of the report, and that the report did not indicate that the worker was incapable of returning to work.

[53] The worker's level of disability was considered by the Board's medical consultant, Dr. B. Prichett, in a memo, dated July 13, 1999. The memo reiterated the worker's restrictions for no heavy lifting, pushing or pulling, repeated or sustained bending or twisting and prolonged sitting, standing and walking. The memo indicated that the worker had a 30% NEL award and that his complaints of pain were consistent with his organic findings.

[54] The worker was seen on August 13, 1999, by Dr. M.J. McCormick, orthopaedic surgeon, who provided a report, dated September 8, 1999. The report stated that the worker had pain between his shoulder blades, radiating in to his neck, that he was "getting pressure in his head and 'can't think'". The worker reported pain in his arms and legs, in his "whole body", that he "shakes a lot", and was having "anxiety attacks". The worker reported an episode of low back pain on July 27, 1999. The report also stated that the worker "stopped working on June 9, 1999 when the pain "got worse". Physiotherapy was prescribed for the worker. Dr. McCormack's report provided the following findings upon clinical examination:

> On examination: height 5'4"; weight 160 pounds. Tender: lower paraspinal cervical muscles, posterior scalenes, upper trapezii. sternoceidomastoid muscles, more so on the left than the right, right infra-spinatus and lower rhomboids. He could get his chin to within one fingerbreadth from his chest and his cervical extension was two-thirds normal. Lateral cervical rotation on the right was half normal and two-thirds normal on the left. Lateral bending on the right was one-quarter normal and one-half normal on the left. L1 to L2 and L5 to S1 were ± tender. He could get his fingertips to within 4 inches from the floor. The rest of his range of lumbar movement was moderately restricted. Heel and toe walking were normal. Reflexes were 4 plus in both upper and lower limbs. Straight leg raising was 75 degrees bilaterally. His heel cords are not tight.

[55] The case materials included a report, dated October 30, 2000, prepared by Dr. Pramila Rao, physiatrist. The report stated that the worker had been seen by Dr. Rao on October 30, 2000, and that he had been seen previously by Dr. Rao in March 1999. It indicated that the worker had experienced "an acute exacerbation of back pain and went off work again on June 9, 1999." The report went on to state, in part:

> Since then, the pain has spread to involve the whole of the body. He complains of intermittent paresthesia in his arms and legs. Also severe problems with headaches. He continues to have problems with sleep disturbance.
>
> He has become quite depressed and was started on anti-depressants.

[56] The report indicated that the worker had been started on Sertraline "since September 27th [sic- 2000 ?] for the depression." Dr. Rao indicated a diagnosis of "chronic pain syndrome" and recommended that the worker receive treatment in a Functional Restoration Program.

[57] On the basis of the medical information, we note that the worker had a "flare-up" of his back pain at work on June 9, 1999. We accept the worker's testimony that he was assigned to an "emergency job" on that date, and accept that he probably was required to perform lifting at that time, which exceeded his restrictions for no heavy lifting. We note that Dr. Noetzel prepared a note, dated June 11, 1999, which indicated that the worker had recently had a "flare-up of his back condition" that was likely related to his work duties.

[58] We have also taken into account Dr. Noetzel's report to the Board, dated June 24, 1999, a few weeks later, which indicated that the worker "has focused on his back condition for a long time", to a degree that could be considered "obsessive". Given that the worker apparently had exhibited this behaviour "for a long time", presumably prior to June 9, 1999, it appears that by June 24, 1999, the worker's non-organic factors were developing, and perhaps overtaking the significance of the organic aspect of his "flare-up" on June 9, 1999.

[59] As noted above, the worker was subsequently referred to Dr. McCormack, who saw the worker on August 13, 1999. Dr. McCormack's report referred to pain between the shoulder blades and pain in the neck, neither of which is an area of the body for which the worker has entitlement. Numbness in the arms and legs and in "the whole body" was also reported by the worker at that time. Again, the worker does not have organic entitlement for these parts of the body. We also note that Dr. McCormack referred to the worker having "anxiety attacks", which is clearly a non-organic condition. As we have indicated above, with detailed reasons, we have concluded that the worker does not have entitlement to benefits for psychotraumatic disability, and entitlement for chronic pain disability is not an issue before us. We also note that, on August 13, 1999, Dr. McCormack carried out a clinical examination of the worker, and we have compared his findings at that time to the findings that were provided at the time of his NEL assessment in 1998.

[60] The case materials indicate that in October 1998, the worker was awarded a 30% NEL award reflecting an organic impairment to his thoracic and lumbar spine. The worker had a NEL assessment that was conducted by Dr. P. E. Bentz, on June 26, 1998, which provided the basis for the organic award. The NEL documentation prepared by Dr. Bentz indicated that the worker had 15° to 29° of flexion, 15° of extension, and 10° of lateral flexion to both the left and right side, all from the neutral position. The NEL documentation indicated that the worker did not have a neurological deficit, and the award did not reflect any neurological deficit.

[61] After reviewing the medical information that was contemporaneous to the June 9, 1999 flare-up of the worker's back condition, we conclude that the worker had a flare-up of his back condition on that date, and that as a result of the incident on June 9, 1999, the worker's condition worsened below the level of impairment reflected by his NEL award, for a temporary period of time. By comparing Dr. McCormack's findings on August 13, 1999 to the findings provided by Dr. Bentz at the time of the worker's NEL assessment in June 1998, we conclude that by August 13, 1999, the worker had returned to his NEL level. We have taken into account Dr. Noetzel's Form 26 that was prepared on August 27, 1999, which indicated that the worker continued to have a diagnosis of "acute and chronic thoracic and lumbar strain", however, taking into account the fact that the worker has a significant 30% NEL award, we find that diagnosis to be descriptive of the level of organic impairment in relation to which the Board has already provided compensation.

[62] Dr. McCormack's examination of the worker on August 13, 1999, indicated that the worker was able to flex his lumbar spine to the extent that his fingertips were "within 4 inches of the floor." Although this is not expressed in terms of degrees of flexion, as the information in the NEL documentation is expressed, we are satisfied that the worker demonstrated more flexion at his examination in August 1999, than he did at the NEL assessment in June 1998 (i.e., only 15-29° of flexion), and that by August 1999, from an organic perspective, he had returned to his NEL level.

[63] As indicated above, however, we accept that the worker had a flare-up of his back pain on June 9, 1999, and that this is supported by the medical information on file. In our view, however, relatively soon after the incident on June 9, 1999, the flare-up resolved and the worker's complaints were characterized primarily in non-organic terms, such as "depression" and "anxiety". This is apparent in Dr. McCormack's report, which considers both organic and non-organic factors. We note that later reports, such as the report, dated October 30, 2000, provided by Dr. Rao, the worker's treating physiatrist, tend to focus on factors which are non-organic in nature, or relate to parts of the body for which the worker does not have entitlement.

[64] We have taken into account the fact that, prior to the flare-up on June 9, 1999, notwithstanding his 30% NEL award, the worker had been able to perform modified work assigned by the employer, but that immediately after the flare-up he was not able to do so. Given this fact, and the medical information provided soon after June 9, 1999, we conclude that the worker was below his NEL level due to organic factors, and that, during a subsequent temporary period, he is entitled to full benefits until his organic condition resolved to its NEL level. Based on the report, dated September 9, 1999, from Dr. McCormack (which was based on an examination of the worker on August 13, 1999), and the comparison of the organic findings in that report to the worker's findings at his NEL assessment, we conclude that by August 13, 1999, the level of the worker's organic impairment had returned to its NEL level.

[65] Accordingly, we find that the worker is entitled to FEL supplementary benefits, pursuant to section 43(9) of the Act, from June 9, 1999 to August 13, 1999. We find that the worker is not entitled to supplementary benefits after August 13, 1999. We note that according to an internal Board memo, dated November 12, 1998, the worker's initial determination date (D1) for FEL benefits was July 1, 1998, and that he was awarded a FEL sustainability award at that time. We find that the worker was eligible to receive FEL supplementary benefits as of June 9, 1999, and given our finding that his level of organic impairment was worse than that reflected by his NEL award (i.e., he was "below his NEL level") during the period from June 9, 1999 to August 13, 1999, the worker is entitled to FEL supplementary benefits during that period. We find that after August 13, 1999, to the extent that the worker was below his NEL level, this was due to non-compensable non-organic factors, as we have indicated above. Accordingly we find that the worker is not entitled to FEL benefits after August 13, 1999, beyond the sustainability award that has been awarded by the Board. The medical information on file supports a finding that, during the relevant period, the worker was participating in a program of medical rehabilitation, as required by section 43(9).

[66] We note that entitlement to a FEL supplement was not an issue directly before the Panel in this appeal, however, in keeping with Tribunal jurisprudence, we conclude that entitlement to a FEL supplement is an issue that is included within the issue of entitlement to a substantive FEL award, and that we have jurisdiction to make this award.

DISPOSITION

[67] The appeal is allowed in part.

i) The worker is not entitled to benefits for psychotraumatic disability.

ii) The worker is entitled to FEL supplementary benefits during the period from June 9, 1999 to August 13, 1999.

iii) The worker is not entitled to further FEL benefits beyond August 13, 1999.

DATED: November 13, 2013

SIGNED: M. Crystal, B. M. Young, R. W. Briggs