WORKPLACE SAFETY AND INSURANCE APPEALS TRIBUNAL

DECISION NO. 1781/05

BEFORE: S. J. Sutherland : Vice-Chair

HEARING: September 27, 2005 at Toronto
Oral
Post-hearing activity completed March 14, 2006

DATE OF DECISION: August 22, 2006

NEUTRAL CITATION: 2006 ONWSIAT 1874

DECISION(S) UNDER APPEAL: Appeals Resolution Officer, E. Mroczek, dated October 2003

APPEARANCES:

For the worker: C. Chenier, from the worker's union

For the employer: The employer has closed.

Interpreter: N/A

REASONS

(i) Introduction

[1] The worker appealed from the decision of the Appeals Resolution Officer, E. Mroczek, dated October 2003. In that decision, the Appeals Resolution Officer found that the worker was not entitled to loss of earnings benefits after March 22, 2002.

[2] I advised the worker and Ms Chenier, at the hearing, that I would be seeking the assistance of an assessor or assessors. On September 29, 2005, I asked S. Granata, the Tribunal's Post-Hearing Coordinator, to arrange to have the worker assessed by an orthopaedic surgeon and a psychiatrist. I provided specific questions that I wished the assessors to answer.

[3] Dr. G. Lloyd, an orthopaedic surgeon, examined the worker on February 1, 2006.

[4] Dr. A. Margulies, a psychiatrist, examined her on February 6, 2006.

[5] I have reproduced the reports of both assessors in section (v) of this decision.

[6] Ms Chenier's final written submissions were dated March 14, 2006.

(ii) Background

[7] The employer was a grocery store.

[8] The worker was almost 29 years old when I heard her appeal. She began working for the employer, as a cashier, in July 1997. She has had the following compensable injuries:

DATE	NATURE OF INJURY	DISPOSITION
August 9, 1997	Psychotraumatic stress disorder as a result of an armed robbery	No lost time; did not seek medical attention until October 2002; did not make claim to the Board until January 9, 2003; claim denied
August 19, 1997	Injured left leg when the safe door fell on it	No lost time apparent

[9] The accident from which this appeal arises happened on July 18, 2001. The worker fell and landed on her buttocks as she was going down the stairs. Her family physician, Dr. S. Lee, reported that the worker had a painful low back, right hand, and right ankle, on August 8, 2001.

[10] The Board accepted the worker's claim.

[11] The worker's condition did not respond to conservative treatment and the Board referred her to a Regional Evaluation Centre for assessment. That assessment took place on November 26, 2001. The assessors reported that her treatment was appropriate. They noted that she appeared to be mildly depressed and recommended evaluation of that condition. They recommended precautions of no prolonged standing or sitting, and no repetitive bending or heavy lifting. These

precautions would decrease over four to six weeks. The assessors also sent the worker for a bone scan, which was normal.

[12] The employer advised that it could accommodate the worker's restrictions, beginning March 11, 2002.

[13] The worker began modified work, at four hours per day, on March 18, 2002. On March 25, the employer's representative telephoned the Claims Adjudicator and said that the worker was crying at work and that she stopped working after a few days and claimed she was in too much pain to continue.

[14] On June 11, 2002, the worker's orthopaedic consultant, Dr. T. Barrington, recommended that the worker return to work "half-time." The worker did not do so.

[15] On June 25, 2002, the Claims Adjudicator denied the worker further benefits.

[16] The worker appealed on July 24, 2002.

[17] Ms Chenier became the worker's representative in September 2002.

[18] The Claims Adjudicator confirmed the denial of ongoing loss of earnings benefits, on January 30, 2003.

[19] The worker applied for Canada Pension Plan disability benefits. Her application was approved on February 11, 2003. Her pension was effective as of July 2001.

[20] The Appeals Resolution Officer, in his decision dated October 9, 2003, found that the worker might have a permanent impairment and ordered an assessment. He agreed that the worker remained partially disabled but denied benefits because she did not make any attempt to mitigate her loss.

[21] The residual impairment in the worker's low back was assessed on January 20, 2004. Following that assessment, the worker was granted a 21% Non-Economic Loss (NEL) award.

[22] The worker appealed to the Tribunal with respect to her entitlement to ongoing loss of earnings benefits.

(iii) The worker's testimony

[23] The worker testified that she started working for the employer in February 1990. Her job was full time and she worked part time in another store. She acknowledged that she was injured in a motor vehicle accident 10 to 12 years earlier and said that she recovered completely. She had no problems with her back prior to starting to work for the accident employer in 1990.

[24] The worker described her job as a cashier and assistant bookkeeper. She said that she had to open the store, get the tills ready for her co-workers, count money, and put the tills into the cash registers.

[25] The worker stated that she tried to return to work after the July 2001 accident. She was given a job stocking shelves. That job involved a lot of reaching, bending, and standing. She had to sort damaged or broken goods which also required standing, reaching, and bending. She was in a lot of pain and found those jobs difficult. Eventually, she could not do them any more. She went to see her doctor who told her she should not put any pressure on her body. She stayed home after that.

[26] Ms Chenier asked the worker about her social life. The worker answered that she used to go to the movies, dinner, and to the shopping mall. She does not do much now. She rated the level of her pain on a good day as 8 or 9. On a bad day it was more than 10. She was taking Tylenol #3 for pain. She had to go to the Emergency Department of her local hospital in January because the pain was so bad. She was treated with morphine. She was not taking anything for stress and was not having any treatment for her back.

[27] Ms Chenier asked the worker about surgery. The worker responded that she consulted a doctor about an operation. The doctor said there was a 70% chance she would improve but she would not be pain-free and she could be worse. She decided not to have the operation.

[28] Ms Chenier asked the worker whether her stress was from the hold-ups or from the accident at work. The worker believed it was the accident at work and the ongoing pain.

[29] The worker said that she had a baby. She found it very difficult coping with being a mother. She described her husband as "father, mother, housewife."

(iv) The medical evidence

[30] Dr. Lee submitted a Physician's First Report to the Board on August 8, 2001. He reported that the worker had a painful low back, right ankle, and right wrist. He referred her to physiotherapy and said that he expected her to recover completely in approximately three weeks.

[31] The worker's lumbar spine and sacrum were x-rayed on August 17, 2001. The x-ray showed that the worker had bilateral spondylolysis at L5-S1, with minimal spondylolisthesis. No other abnormalities were detected.

[32] The physiotherapist assessed the worker's condition on August 14, 2001. Her working diagnosis was an acute injury to the worker's sacroiliac joint. She also reported that the worker would recover completely.

[33] On August 28, 2001, Dr. Lee reported the findings of the worker's x-ray. He continued to indicate that she should recover completely.

[34] The worker consulted Dr. Barrington on September 19, 2001. Dr. Barrington noted that the worker's mother was also a patient of his. Dr. Barrington said that the worker had a spina bifida occulta[1] at L5. His opinion was:

---

[1] Spina bifida occulta is defined in the Merriam-Webster medical dictionary as "a congenital cleft of the spinal column without hernial protrusion of the meninges."

> This young lady has sustained recent trauma to her back superimposed on spondylolisthesis.

[35] Dr. Lee diagnosed a low back strain, on October 3, 2001.

[36] The physiotherapist requested an extension of treatment, on October 18, 2001. She reported that the worker's condition was improving but the range of motion in her lumbar spine was limited on extension.

[37] Dr. Barrington said that the worker was "modestly improved" on October 24, 2005.

[38] The physiotherapist recommended another treatment extension on November 22, 2001 and January 7, 2002. The worker's range of motion was limited in all directions, by pain.

[39] Dr. Lee submitted routine progress reports to the Board on November 23, 2001, and August 6, 2002.

[40] The assessors at the Regional Evaluation Centre that the worker attended on November 26, 2001, reviewed the worker's work history, the history of her injury and treatment, her current complaints, her past health, and her personal and social history. They reported on their physical examination of the worker. Their clinical impression was:

> [The worker] presents with a history suggestive of a lumbar contusion/strain.
>
> There appeared to be some intercurrent psychosocial issues associated with the chronicity of her complaint.

[41] The assessors thought that the worker's prognosis was favourable. They concluded that there should be precautions on the worker's activities for a short period of time. Those precautions were: no prolonged standing and sitting, repetitive bending, or heavy lifting for four to six weeks.

[42] Dr. Barrington confirmed that the worker was not able to return to work on December 12, 2001.

[43] The worker had a bone scan on January 25, 2002. It was normal.

[44] Dr. P. Malcolm, an orthopaedic surgeon, was one of the assessors at the Regional Evaluation Centre. His final prognosis, which was dated February 6, 2002, was:

> The prognosis for [the worker]'s recovery from this injury from a functional perspective should be quite satisfactory, however, the time frame for resolution of her subjective complaints in the context of the apparent psychosocial co-morbidities remains indeterminate.

[45] Dr. Barrington recommended that the worker return to work on a half-time basis, on February 19, 2002.

[46] On March 12, 2002, the worker told Dr. Barrington that the Claims Adjudicator "expects her to get back to full-time work on March 18, 2002." Dr. Barrington did not think the worker could

work full-time and recommended a work hardening program starting at four hours per day for two weeks, increasing to six hours per day for two weeks and then her regular hours.

[47] On April 3, 2002, Dr. Barrington reported that the worker had worked for a total of 14 hours and "says that she is unable to cope because of back pain." Dr. Barrington said that the worker appeared depressed. He prescribed Valium and recommended that she increase her activity level. He also recommended that she attend a pain management clinic.

[48] The worker consulted Dr. M. Chapman, an orthopaedic surgeon, on April 9, 2002. Dr. Chapman referred her for a CT scan.

[49] On April 19, 2002, Dr. Chapman reported:

> I have reviewed this lady's x-rays. She really has a bad problem. She has a spondylolytic spondylolisthesis at L5. She also has a spina bifida occulta at S1. It has been my experience that this pain is not likely to go away. I still await the CT scan to see if she has any amount of nerve root compression.
>
> Once again it has been my clinical experience over twenty years that the pain due to the spondylolisthesis is not likely to disappear within a reasonable time frame.

[50] Dr. Lee opined, on May 1, 2002, that the worker was not able to work because of back pain. He referred her to a pain clinic.

[51] On June 11, 2002, Dr. Barrington reported that the worker slipped and fell on her right knee two weeks earlier. He again suggested that the worker return to work part time.

[52] Dr. S. Lee's medical report in support of the worker's application for Canada Pension Plan disability benefits was dated July 17, 2002. Dr. Lee said that the worker "fell downstairs on 25.18.01 [and was left with] persistent low back pain."

[53] Dr. Chapman reported, on June 18, 2002, that the worker had a CT scan which confirmed a Grade 1 spondylolitic spondylolisthesis at L5. He did not think that the pain in the worker's back would improve without surgery, which had a 90% success rate. Dr. Chapman commented that the worker was getting married in two months "and this, naturally, occupies more of her time than her backache presently."

[54] A Board Medical Adviser, Dr. G. Shapiro, reviewed the medical evidence on June 21, 2002. Dr. Shapiro said:

> 1. The objective clinical findings suggest that this worker is fit for activities that avoid heavy lifting, repetitive bending and prolonged positioning.
>
> 2. A significant improvement is anticipated in this worker's condition and I recommend we review the prognosis on receipt of subsequent reports.

[55] On July 10, 2002, Dr. Barrington stated that the worker "remains disabled and finding it harder and harder to cope." He also recommended surgery.

[56] The Claims Adjudicator asked whether the worker's pre-existing condition was minor. Dr. Shapiro answered, on July 12:

> The spina bifida occulta and grade 1 spondylolitic spondylolisthesis represents a moderate pre-existing condition that is likely prolonging this claim.

[57] The worker saw Dr. F. Lee, a consultant in psychiatry, on October 10, 2002. Dr. Lee reported:

> [The worker] has been traumatized by 2 robbery attempts at work in 1996, leading to chronic post-traumatic stress symptoms. She also slipped and fell at work on July 18, 2001, which will need surgical intervention down the road. There are still moderate disturbances of her neurovegetative signs.

[58] Dr. Lee diagnosed chronic post-traumatic stress disorder.

[59] The worker had an MRI on October 17, 2002. This revealed:

> Multi-level degenerative disc disease. The most significant level is L5-S1 where the left neural foreman is narrowed due to combination of left lateral disc protrusion and left facet joint hypertrophy, the combination potentially impinging the existing left L5 nerve root.

[60] Dr. W. Kraemer, an orthopaedic surgeon, examined the worker on December 3, 2002. The worker had: "significant low back pain in the midline and in the left paralumbar region, with radiation to her left buttock and down her posterior lateral calf into her foot, with occasional numbness and tingling in the left big toe." Dr. Kraemer said the following with respect to surgery:

> As you know, this is a very difficult problem to deal with. Decompression of the left L5 nerve root alone would result in further destabilization of the spondylolisthesis. Therefore, any surgical procedure would also need to involve instrumentation and fusion of the L5-S1 level. However, she already has degenerative changes and an annular tear at the L4-5 level and therefore this would rapidly deteriorate after stabilization of the level below. Hence, she would require fusion from L4 to the sacrum. This is a large operation and would require a significant amount of recovery time, and she certainly would not be free of back pain after this procedure. I am not certain that her functional improvement would be sufficient to justify the risks involved.

[61] Dr. Kraemer also said that the worker's pre-existing spondylolysis was "completely asymptomatic"; the workplace accident rendered it "severely symptomatic," and, therefore, compensable.

[62] Dr. Barrington opined, on January 8, 2003, that it was a 90% chance of pain relief with surgery. On April 29, 2003, Dr. Barrington stated that the worker's symptoms were unchanged and she had intermittent acute flareups. Dr. Barrington characterized the worker's back pain as "grumbling" and "mechanical in nature," on November 26, 2003. On January 13, 2004, Dr. Barrington noted that the worker was pregnant. She had acute low back pain with radiation into her buttocks.

[63] Dr. M. Chain, a Board Medical Adviser reviewed the medical reports on file on January 28, 2003. Dr. Chain stated that the recommended surgery was required by the worker's underlying spinal pathology and was not compensable.

[64] Dr. Barrington saw the worker on January 18, 2004. The worker reported having several acute episodes of pain. He recommended surgery.

[65] On April 26, 2005, Dr. Kraemer reported:

> [The worker] is severely disabled, approximately 4 years after her work-related injury. Prior to that, she was not having any significant back problems. She is unable to do any type of work. Even with surgery, the likelihood of returning to gainful employment is low."

[66] The worker's family physician reviewed his file with respect to the worker on August 26, 2005, and provided a chronological account of her care. Dr. Lee said that the worker had "NO low back symptoms prior to her accident." He noted that the worker's back pain increased during her pregnancy. She had a recurrent episode of severe low back pain on January 3, 2005.

[67] On November 24, 2005, Dr. P. Charlebois, an anaesthetist, advised the Tribunal that he saw the worker on January 18, 2002. He had a record of the bill for the consultation. All other records had been destroyed.

(v) The assessors' reports

(a) Dr. Lloyd's report dated February 10, 2006

[68] The opinions expressed rely on the history, the examination, and a review of all the documentation was listed above.

> This report will be in two parts. There will be an initial overview of the evolution of this patient's complaints, together with my interpretation of the cause for her complaints.
>
> Secondly, I will respond to the specific questions which were raised by the panel reviewing this lady's appeal, who (for the record) is now married and goes by the name of [the worker's married name].
>
> This lady is currently aged 29 and right-handed. She married in September of 2002. When the incidents that have led to her perception of her being disabled started, she was residing with family members in a house in the Markham area. She is now residing in her own home in the Whitby area with her husband and her daughter, who is now aged 1 1/2. As a matter of record, she drew to my attention that in the WSIAT memorandum dated the 29th of February 2005, there is a statement that she had a seven-pound, four-ounce baby in 1993. She indicated that she did not have a child in that year, and the only child that she has had is the one who is now aged 1 1/2 years.
>
> Her formal education is quite limited. She has obtained Grade 9. She told me that she had worked as a cashier and bookkeeper, and had worked at [the employer]. It was her history that she last worked on the 18th of July 2001. There was an attempt to re-establish her in the workforce following a work hardening program. This started on the 22nd of March 2002. She tells me that she was able to work for two or three days. She has not worked since that date.
>
> Her pre-accident health is noteworthy, in that she would have migraines once a month. They are not quite typical migraines. She denied having any other instances of personal injury, surgery or significant illness. She specifically denied having any symptoms from her lumbar spine or left lower limb; those being the two areas that are currently of concern.
>
> She indicated that her symptoms were precipitated by a fall which occurred on the 18th of July 2001. It was her history that she slipped down three stairs, landed on her bottom tilted to the right. Her lower limbs were out straight, which meant that her hips were flexed at 90° and her knees were fully extended.
>
> She tells me that she was promptly aware of pain to her lumbar spine.

She was also aware of pain to her right wrist and right ankle, although these pains resolved quite promptly over a matter of a few days.

During the course of the first week after the accident, she was aware of pain radiating to her right lower limb.

Her initial management was at the hands of Dr. Lee. The initial postulated diagnosis was that of a sacroiliac joint injury, although (with the benefit of hindsight) I think this was improbable.

Her symptoms persisted.

She had routine x-rays which identified the presence of a developmental defect at the lumbosacral junction, specifically a spondylolysis and spondylolisthesis.

There were initial attempts to treat her with a brace. This did not relieve her symptoms.

Therefore, further investigations were initiated. In May of 2002, she had a CT scan of her lumbar spine, which showed the presence of the spondylolisthesis, but makes no reference to any nerve root compression. In October of 2002, she had an MRI examination completed at the North York General Hospital; that being the one that is referred to earlier in the report. The report of that investigation identifies multi-level degenerative disc disease and the spondylolisthesis. It does raise concerns that, as a combination of a disc protrusion and facet joint hypertrophy, there could be impingement on the left L5 nerve root.

Shortly after having this MRI examination, she had a consultation with Dr. Kraemer. Dr. Kraemer records, on the 3rd of December 2002, that she had left paralumbar pain with radiation to her left buttock, down her left lower limb, with occasional numbness into her left big toe. He also notes some motor weakness.

At that time then, one would have come to the diagnosis that this patient had a pre-existing developmental abnormality to the lumbosacral junction - specifically the spondylolysis and spondylolisthesis; that she probably was experiencing radiculapathy to her left lower limb affecting the L5 nerve root; and, for reasons that are unclear, that she had multi-level degenerative disc disease.

Since that time, her symptoms have persisted. She has had a number of consultations and surgical treatment has been discussed.

She finds that she is significantly disabled, in that she has difficulty walking, standing or sitting. She remains at home most of the time, and tries to offer non-physically challenging child care. She carries out very little in the way of housework. She tells me that she has episodes once every five or six weeks, when her pain is so severe that she has to crawl around the house and she has to have help to go to the washroom.

She does take Tylenol 3. She will take two on the days when her symptoms are not overly intrusive. She will take between five and six on the days when her symptoms are particularly severe.

She does not drive. She was driven to this appointment by her father-in-law.

When it came to examining her, she looked quite tense. She is clearly verbally very pain-focused and very introspective about her situation. She went on to criticise some of the comments that had been made in the WSIAT memorandum - one of which I have referred to above, specifically when her child was born.

She moves very slowly. She walks leaning forwards, with her lumbar spine flexed to about 20° and tilted to about 10° to the right. It is difficult to be certain whether or not she has involuntary muscle spasm to the left, as she would not put her lumbar spine in a position that would relax this muscle.

She virtually has no movement in her lumbar spine on formal examination. She does have weakness to her left lower limb in a manner that could correspond with the 5th lumbar myotome.

She has a sensory alteration which is non-anatomic. Her straight leg raising was inappropriate. It was 10° in the lying position and 90° in the sitting position. Her tenderness was inappropriate. Her reflexes were symmetrical.

From a diagnostic perspective then, one is faced with a patient who, given the imaging studies, would be expected to have mechanical symptoms from her lumbar spine, but not of the magnitude portrayed, who could be experiencing radiculopathy to her left lower limb; however, the absence of straight leg raising limitation in the sitting position would suggest that it is not overly severe.

Given the inappropriate findings that are present, there is almost certainly a measure of pain amplification. The inappropriate findings of inconsistent straight leg raising, inappropriate tenderness, and non-anatomic sensory alteration to her left lower limb, would be supportive of this position. It falls within the purview of an orthopaedic assessment to comment on its presence; however, the reasons for the pain amplification will have to be addressed by specialists in the field of psychopathology. I am aware that she is being seen by Dr. Marguiles.

As a matter of record, when I saw her, she portrayed herself as being profoundly disabled.

Addressing then the questions that are posed in the WSIAT memorandum of the 29th of September 2005:

The term spina bifida occulta means that, at one single level (specifically the L5 level), during the course of development, two pieces of bone (specifically those at the back of the vertebrae), have not fused together normally. This is of no consequence as it relates to this patient. It would not be a source for her complaint or continuing disability. It is a coincidental finding.

The term spondylolysis means that, in this patient, her lumbar spine did not develop normally at one level (specifically the L5 level), and that the two elements posteriorly did not attach themselves appropriately to that part anteriorly. As a consequence, this let the vertebra above slip relative to the one below. This is what is meant by a spondylolisthesis. The cause for this condition in this patient is almost certainly developmental. This condition, of itself, is not painful; however, it is frequently rendered painful by an injury. The usual course of pain precipitated from this condition is uncertain. Sometimes, the symptoms resolve. Sometimes, they persist to varying degrees, being managed on occasions by ergonomic adjustments; on other occasions by spinal fusion, depending on the severity.

The effect of the fall and landing on her buttocks (relying on the patient's subjective observations) would be that symptoms were or could have been precipitated. Unfortunately, there is no ordinary course of events following this set of circumstances. As I have indicated above, sometimes symptoms resolve; sometimes they do not. It is really a matter of awaiting events. Given the length of time that has elapsed with this patient, they are probably not going to resolve.

As to the tomographic bone scan, which showed the results being normal, I do not believe you can reasonably rule out any osteoarthritic changes.

Yes, it’s unusual for a patient to have the multi-level degenerative disc disease that was identified in the MRI examination of the 17th of October 2002. It is unusual in a patient who is only 26 years of age.

There is no relationship between her weight and her ongoing symptoms.

As I have indicated above, it was this patient's history to me that she did not have a baby in 1993.

In the text above, I have described the findings on physical examination and the diagnosis of this worker's condition. By way of clarification, she has mechanical lumbar symptoms. She also has radiculopathy, and her symptoms are compounded by pain amplification.

If I rely on the patient's subjective comments, there is a relationship between the workplace injury on the 18th of July 2001 and her complaints.

The overall presentation of her disability is significantly greater than I would have anticipated, even accepting that she does have an impairment.

Whilst it was reasonable for the physicians and physiotherapists managing her initially to be optimistic that she would recover completely, and in fact some patients do, some do not. Her symptoms have persisted because she did have a structural abnormality to her lumbar spine, and also she has pain amplification.

As to whether or not she is capable of returning to work, if one views her ability profile from a purely musculoskeletal perspective and disregards pain amplification and whatever psychopathology is subsequently identified, then patients with the structural changes that are seen with this lady would be capable of working in a sedentary capacity on a part-time basis, and some patient would be working on a full-time basis.

Finally, one would have empathy for her treating surgeon's caution about offering her surgical treatment. Whilst hypothetically the structural change of spondylolysis and spondylolisthesis and any compression that she has on the 5th lumbar nerve root would be capable of being improved by surgery, there are many precedents for caution when it comes to operating on patients with pain amplification, as frequently (even if the structural changes are improved by fusion and decompression) patients continue to have symptoms, and indeed sometimes have more symptoms. An added caution with this patient would be that, if she were to have a fusion procedure, this would place added stress on her upper intervertebral discs, which are already showing signs of degenerative change.

(b) Dr. Margulies' report dated February 6, 2006:

As arranged and in my capacity as a medical examiner, I undertook a psychiatric evaluation of the above captioned on January 20, 2006, meeting with [the worker] for a period of two hours. Prior to preparation of this report I was provided with documentation said to encompass the entire case record; specifics of this are appended to this report.

Identifying Data

[The worker] is a 29 year old married woman living with her husband and young daughter in an owned house in Whitby, Ontario. But for a very brief and limited attempt at modified work in 2002, [the worker] has not worked for pay for the past more than four and one half years and currently was in receipt of Canada Pension Plan disability and NEL benefits. She was fully aware of the nature and purpose of this psychiatric evaluation and, in acknowledgement thereof, had already signed a Health Professional Medical Release Form.

Accident History and Sequelae

On July 18, 2001, while employed on a full time basis for the preceding four years as a cashier in a grocery store, [the worker] reportedly tripped while descending a staircase and slid on her buttocks down three stairs. Immediately symptomatic with pain in her low back, right hand and right ankle, she came under the care of her personal physician, Dr. S.P. Lee, and in the course of time was treated with various medications and physical therapies. While hand and ankle pain resolved uneventfully, [the worker] reportedly

continued to experience unremitting pain in her lower back. She underwent various investigations and was seen in specialist consultations by Dr. T. W. Barrington, orthopaedist, and Dr. W.J. Kraemer, orthopaedist, and while bilateral spondylolysis at L5/S1 with minimal spondylolisthesis was identified, she reportedly attained no appreciable improvement. Roughly one and a half years following the above noted injury, for reasons unknown, [the worker] became more symptomatic with increased low back pain and radiation down her left leg along with impaired ambulation.

Symptoms further intensified during a recent pregnancy, described as a "difficult" one and to date [the worker] has reportedly remained painfully symptomatic and unable to work. She has continued under the care of Dr. Lee and identified sole current treatment with acetaminophen/codeine compound (Tylenol #3; opioid analgesic).

More to the point of this psychiatric examination, [the worker] reported that, within a time frame and manner which she was unable to describe, she developed a "posttraumatic stress disorder" (PTSD) which she defined in terms of "being sad and upset" and which she attributed to her persisting accident-related pain and limitations and diminished income. [The worker] reported a pain disrupted pattern of sleep but upon specific inquiry denied experiencing any repetitive dreams of the subject accident or of any other events but for the occasional one of being paralyzed. In further elaboration, she indicated crying frequently and feeling angry and frustrated, particularly in relation to what she believed to be the denial of benefits which she considered her "right" and to which she believed she was "entitled." She specifically denied ("never") any thoughts of dying or of self harm, or feelings of hopelessness, noting that she has remained optimistic that she will eventually "get better." In contemplation of her predicament, she has, at times, ruminated about her impairments and disabilities but denied re-experiencing the accident, such as in intrusive thoughts or feelings as if it were recurring. No alteration in her appetite was reported and she indicated that since adolescence she has always been very slim and unable to gain weight.

More or less equating "posttraumatic stress disorder" with "depression," [the worker] was in attendance upon Dr. F. Lee, a psychiatrist to whom she was referred by her personal physician, on perhaps six occasions in the latter months of 2002 and early months of 2003. She was treated with citalopram (Celexa; antidepressant) for a period of some months but reportedly attained no appreciable improvement - in terms of feeling less "depressed" or thinking less of the pain - and terminated therapy upon her own initiative. She apparently has sought no further specific specialist treatment since that time although has continued in attendance upon Dr. S.P. Lee.

It is noteworthy that [the worker] made no spontaneous mention or association of "posttraumatic stress disorder" with two criminal events in which she was involved to a greater or lesser extent within a matter of ten days in 1997. While she did complain of having developed a "posttraumatic stress disorder" and Dr. F. Lee had concluded that she had done so as a result of having been "traumatized by two robbery attempts at work in 1996 (sic), because PTSD is, in part, characterized by increased arousal, it would not be unexpected that reference to the purported precipitating event(s), as suggested by Dr. Lee, would have been forthcoming had either been relevant.

Past and Psychosocial History

In order more fully to understand [the worker]'s basic characterological structure and what role it may play in her current difficulties, a review of her past and psychosocial history was undertaken. It was learned that she was born and raised in Toronto, the only daughter and second in a sibling of three children of Yugoslavian-born parents of Albanian ethnicity. She superficially reported a problem and trouble free upbringing in which her needs for love and affection were adequately met but, overall, revealed little in terms of her significant feelings, attitudes and relationships throughout her important developmental years. Her father, a former truck driver presently 61 years of age, has been, as a result of a work-related motor vehicle accident, disabled for the past 20 years

and in receipt of WSIB and Canada Pension Plan disability benefits. He was simplistically described as "very nice" and a generally supportive parent who "did what he could" but it was never explained what it was that he did do. Her mother, eight years younger than her spouse, was described as a "very good" parent who is said to have enjoyed a good relationship with her husband. For the past roughly 15 years, like her spouse she has been disabled as a result of a work-related accident and has been in receipt of WSIB and Canada Pension Plan disability benefits.

When she was 15 or 16 years old, purportedly in order financially to assist her family, [the worker], an "average" student, left school with a grade IX education. She continued to live with her parents and obtained initially part time and, since 1997, full time work as a cashier in a grocery store and was thusly employed at the time of the accident in question. In 2002, more than one year after the subject accident and after three years of courtship and no prior dating experiencing, she married a man four years her senior, a mailman employed with Canada Post. She was emphatic in having enjoyed an excellent marriage and that her husband was “the best” spouse and father.

There has been one child of this union, a daughter born in August, 2004 and almost one and a half years of age at the time of this examination. [The worker] indicated that, because of back pain, she has experienced difficulties in caring for her child and, for the same reasons, has been generally avoidant of sexual intimacy. She was emphatic, nonetheless, in her expression of love for and of being loved by her husband and that notwithstanding her avoidance of sexual intimacy, her spouse has remained supportive and understanding.

Mental Status

Mental status assessment revealed a thin, casually but neatly dressed, plainly groomed, sallow complexioned, 29 year old woman of average height. She walked in a slow and laboured manner, keeping her hand against her lower back, and throughout the two hours of this examination repeatedly displayed numerous, so-called pain behaviours: groaning softly, holding her lower back, and, on many occasions, standing up purportedly to relieve her lumbar discomfort. She related in a simplistic, responsive but not entirely spontaneous manner and, for the most part, was focused upon her complaints of pain. She seemed to have little depth of understanding in terms of her subjective complaints of "depression" and even less of "posttraumatic stress disorder," for the most part simplistically and superficially reporting feelings of sadness and anger. At no time did she display any objective signs or make subjective complaint of emotional distress when speaking of the purported precipitants of her PTSD - pain, limitations, financial restrictions - and made no mention of either criminal event in which she had been involved in 1997. Her affect (mood) was mildly dysphoric (depressed) but could be readily engaged with a broad and appropriate range of mood. There were no signs of a thought disorder or of other psychotic phenomena or any indications of organic brain dysfunction. Her sensorium was generally clear, memory somewhat globally limited but essentially intact, and cognitive abilities likely in the low average range. She had little psychological awareness or sophistication, was prone to more concrete as opposed to abstract thinking, with insight limited to primarily a somatic or pain focus as the cause of all her difficulties.

Opinion

Overall, a comprehensive understanding of [the worker]'s basic characterological structure could not fully be determined but what did emerge, based upon her historical account, pointed to an individual of modest cognitive abilities and limited education who, nonetheless, was vocationally productive and had not experienced any prior emotional difficulties. As a result of the work-related accident of July, 2001, [the worker] would appear to have sustained various physical injuries, the nature and extent of which are outside the scope of this psychiatric examination and have been addressed by those with appropriate expertise. Suffice it to say that notwithstanding the passage of time and

treatment, in the some four and a half years which have elapsed since that accident, she has continued to complain of severe low back pain and has, but for a brief and unsuccessful attempt in 2002, purportedly remained vocationally disabled.

Reported symptoms of sadness, irritability and tearfulness suggest some form of depressive illness which, in view of the absence of any sustained sense of dysphoria or hopelessness and retained optimism is, likely a mild adjustment disorder with depressed mood, secondary to her persisting painful symptoms. Specifically, there is no compelling evidence to support the diagnosis of a major depressive disorder or a posttraumatic stress disorder. The latter is a condition which may develop in roughly 10% to 25% of persons exposed to a life threatening event associated with feelings of intense fear, helplessness or horror and is characterized by the persistent re-experiencing of the traumatic event (in terms of intrusive thoughts, recurring distressing dreams or feelings or dissociative flashbacks as if it were recurring, or intense emotional distress or physiological reactivity upon exposure to circumstances reminiscent of the trauma event), a persistent avoidance of circumstances or stimuli associated with the trauma and a numbing of general responsiveness (such as efforts to avoid thinking or feeling about or activities reminiscent of the trauma, an inability to recall an important aspect of it, marked disinterest or withdrawal from significant activities, a sense of detachment or estrangement from others, restricted range of affect and/or a sense of foreshortened future), and ongoing symptoms of increased arousal (e.g. sleep disturbance, irritability, difficulties in concentration, hypervigilance and an exaggerated startle response). On the basis of this examination and a review of the provided documentation, there are simply insufficient documented symptoms and signs to fulfil the diagnostic criteria for PTSD whether precipitated by one or both criminal incidents of 1997 or the slip and fall accident of 2001.

Symptoms of this adjustment disorder with depressed mood have been generally mild and, of themselves, have resulted in very mild symptomatic impairment but without any form of disability. [The worker] has likely developed this adjustment disorder as a direct reaction to her persisting complaints of pain. This is a not uncommon event and, in this instance, is reflective of her limited adaptive capacity and coping skills. I can find nothing, upon this psychiatric examination, sufficiently to explain [the worker]'s persisting painful complaints on the basis of a psychiatric disorder.

While it is possible that an event such as the initial armed robbery in which she was involved may have been a sufficient stressor to result in the development of PTSD, the absence of any complaints thereof between the time of the incident and, it would appear, consultation with Dr. F. Lee, strongly speaks against such a likelihood. Furthermore, there is nothing to indicate that her immediate reaction to the armed robbery was one of intense fear, helplessness or horror; she was able to continue working in the same environment in which the robbery occurred. She made no mention of it nor is known to have shown any signs of emotional distress. The accident of 2001 when [the worker] fell down three stairs is very difficult to equate to the extreme traumatic stressor involving actual or threatened death or serious injury and to the associated feelings of fear, helplessness or horror which, by definition form the necessary precipitating factors of PTSD.

In summation, in terms of her emotional state, [the worker] has likely developed a mild adjustment disorder with depressed mood in reaction to her persisting complaints of pain and associated impairments. There is no compelling evidence of the presence of a posttraumatic stress disorder or that the slip and fall incident of July, 2001 or earlier criminal incidents in which she was involved in 1997 have been thusly significant.

(vi) The Law and policy

[69] The *Workplace Safety and Insurance Act, 1997* (WSIA) took effect on January 1, 1998, and applies in this appeal. Pursuant to sections 112 and 126 of the WSIA, the Appeals Tribunal is

required to apply any applicable Board policy when making decisions. The Board has identified certain policies applicable to this appeal and I have considered these policies as necessary in deciding this appeal.

(vii) Conclusions

[70] Despite her young age, the worker has multilevel degenerative disc disease. She also had pre-existing spondylosis and spondylolisthesis that were developmental in origin.

[71] In the decision dated October 9, 2003, the Appeals Resolution Officer found that the worker aggravated her pre-existing condition in the compensable accident; she was partially impaired as a result of the compensable accident; she was entitled to an assessment of the residual permanent impairment; and she was not entitled to loss of earnings benefits because she considered herself to be totally disabled and made no attempt to mitigate her wage loss.

[72] As I noted above, the worker received a 21% NEL award. The quantum of her award indicates that the worker is partially impaired and capable of suitable activity.

[73] Dr. Lloyd, in his report dated February 10, 2006, commented that the worker "portrayed herself as being profoundly disabled." Dr. Lloyd confirmed that the fall could have aggravated the worker's pre-existing developmental abnormalities. Dr. Lloyd reported inappropriate responses when he examined the worker. He diagnosed mechanical lumbar symptoms with radiculopathy and pain magnification and commented that the "overall presentation of her disability is significantly greater than I would have anticipated..."

[74] Dr. Lloyd opined that "from a purely musculoskeletal perspective... patients with the structural changes that are seen with this lady would be capable of working in a sedentary capacity on a part-time basis, and some patients would be working on a full-time basis."

[75] In his report of February 2, 2006, Dr. Margulies diagnosed a "mild adjustment disorder with depressed mood, secondary to her persisting painful symptoms." Dr. Margulies said that the adjustment disorder "resulted in very mild symptomatic impairment without any form of disability." In his opinion, the worker did not have either a major depressive disorder or post-traumatic stress disorder.

[76] To summarize, the worker has multilevel degenerative disc disease and spondylosis and spondylolisthesis that are developmental in origin. Her pre-existing conditions were asymptomatic prior to the compensable accident of July 18, 2001. She has had low back pain ever since that accident. Her residual permanent impairment was recognized with a 21% NEL award. However, the worker has maintained that she is totally disabled and unable to return to work.

[77] According to Dr. Lloyd, the worker's organic condition is not sufficiently severe as to prevent her return to suitable work. Dr. Margulies said that the worker's adjustment disorder and depression were mild.

[78] The worker is not having any treatment for her back but is taking Tylenol #3.

[79] On the basis of the evidence set out above, I find that I must agree with the Appeals Resolution Officer. The worker remains partially disabled but she is capable of returning to work and she has not made any effort to find employment.

[80] In her submissions dated March 14, 2006, Ms Chenier likened the worker's pre-existing condition to a "thin skull." She noted that Dr. Lloyd said the worker's symptoms were not likely to resolve because of the length of time that had elapsed since the accident. Ms Chenier commented that there has been no event, other than the compensable accident, that has caused the worker's ongoing disability.

[81] I agree with all Ms Chenier's comments. However, the issue before me is not whether the worker has an ongoing disability. It is whether the worker's disability is sufficiently severe as to prevent her from returning to work in some capacity. The fact that the worker has a disability was recognized by her NEL award. I have found that the evidence does not support the worker's claim that she is totally disabled and unable to do any work.

[82] Ms Chenier reviewed Dr. Margulies' report and said: "we believe that Dr. Margulies supports the union's whole argument." She quoted from that portion of Dr. Margulies' report in which he said that the adjustment disorder was a direct reaction to the worker's ongoing complaints of pain.

[83] Again, I agree with Ms Chenier's comments. However, the issue is whether the adjustment disorder and the organic impairment are sufficiently severe that they would prevent the worker from returning to work. Dr. Margulies said that the adjustment disorder was not. I have ruled that the adjustment disorder and the organic impairment taken together do not render the worker totally disabled.

[84] Ms Chenier concluded:

> In conclusion, the Union wishes to point out that prior to July 17, 2001, [the worker] was asymptomatic of any physical or mental impairment. In Operational Policy #03-01-01 we can see where the definition of an accident includes a disablement arising out of and in the course of employment and is an unexpected result of working duties.
>
> [The worker]'s fall down those stairs at [the employer's] was and is the significant contributing factor for her disabled condition as she presents to-day and that includes her pain.
>
> Again, the Union would reiterate prior decision and reasoning as found in Decision #3113/01 as attached on Page #4 & 5- highlighted for your convenience [there is no highlighting in the submissions that were sent to me].
>
> Also, on Page 41 of the C/R, one can find where SIEF of 50% was allowed the accident employer.
>
> When one examines the merits and justice of the case and see [the worker] as a whole person who has no real options but to endure this disability - we believe that based on all the evidence, both subjective and objective, the appeal should be successful.

[85] There is no question that the worker was asymptomatic prior to the compensable injury. There is also no question that she had a permanent impairment after the injury. As I have said in other places in this decision, the impairment was recognized by the 21% NEL award. The issue that is before me is whether the worker was entitled to loss of earnings benefits after March 22, 2002. I

have found that the worker was partially disabled and capable of performing some kind of work. Therefore, she is not entitled to the requested loss of earnings benefits.

[86] Ms Chenier referred me to *Decision No. 3113/01*. The worker in that case had pre-existing severe degenerative disc disease and spondylolisthesis that was asymptomatic before he injured his back at work on February 12, 1997. The Board initially denied entitlement but an appeal to the Tribunal resulted in the granting of entitlement. Following release of the Tribunal decision, the Board paid the worker temporary benefits between February 13, and October 6, 1997. On the latter date, the worker returned to modified work, on a part-time basis, with a different employer. The worker had a loss of earnings of approximately $24,000 per year.

[87] The Board ruled that the worker recovered from the compensable injury and found that his ongoing symptoms were the result of his underlying spondylolisthesis. Accordingly, the Board denied the worker loss of earnings benefits after he returned to work on October 6, 1997.

[88] The issue before the Vice-Chair who heard the worker's appeal was whether the worker was entitled to benefits after October 6, 1997.

[89] The Vice-Chair ruled that the worker was "entitled to full temporary partial disability benefits less the amounts that he earned from October 6, 1997 to date, to be followed by a FEL [future economic loss] determination based on his current job." The Vice-Chair ordered a NEL assessment of the permanent aggravation of the worker's underlying disc disease.

[90] The facts in *Decision No. 3113/01* are significantly different from the facts before me. In particular, the Board did not accept that the worker in *Decision No. 3113/01* had a permanent aggravation of his pre-existing non-compensable condition. The worker in the appeal before me had a NEL examination.

[91] The worker in *Decision No. 3113/01* returned to modified work on a part-time basis. The worker in the appeal before me has not.

DISPOSITION

[92] The worker's appeal is denied.

[93] The worker is not entitled to loss of earnings benefits after March 22, 2002.

DATED: August 22, 2006

SIGNED: S. J. Sutherland