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DN: 383/91
STY:
PANEL: Moore; Beattie; Nipshagen
DDATE: 131192
ACT:
KEYW: Apportionment (pensions); Psychotraumatic disability; Pensions (assessment) (psychotraumatic disability); Pensions (assessment) (whole person concept).
SUM: The worker, who was 61 years of age, appealed the level of his 65% pension.

When he was 19, the worker attempted suicide. In 1962 he injured his lower back and he received temporary benefits until 1964. He was awarded a 10% pension which was increased to 15% in 1968. From 1970 to 1984 the worker was successfully employed, happily married and made few complaints about his back condition. In early 1984 the worker began receiving regular medical treatment for back pain. By late 1984 the worker's condition began to deteriorate dramatically and he began to show symptoms of serious neurological deficit secondary to his back injury.

In 1984 or 1985 the worker sold his house and invested the proceeds in a business. This began the process of the breakdown of his marriage. In August 1986 the worker was involved in an automobile accident. He began reporting seizures, stress and uncontrolled back pain in October 1986. The worker attempted suicide by drinking antifreeze in January 1987. This had serious adverse effects on his subsequent condition. In the summer of 1987 the worker again attempted suicide by using Valium. In July 1987 the worker's pension for organic back pain was increased to 50%. The Hearings Officer increased the award to 65% based on recognition of a substantial psychiatric disability.

The Panel agreed that the 65% overall award was correct but wished to emphasize the importance of the process by which this figure was arrived at. The Board's whole person approach requires that all aspects of the worker's impairment of earning capacity be considered as a first step in determining entitlement to a pension. Once the full extent of that impairment has been determined, Board policy then apportions the overall assessment to determine the proportion of the worker's overall disability attributable to compensable factors.

The worker's psychiatric disability fell within Category III of the Psychotraumatic and Behavioural Disorders Rating Schedule. He had periods of severe anxiety accompanied by a significant deterioration of his social and family relations. Severe depression had led to the two suicide attempts.

In this case the worker's overall impairment of earning capacity was 100%, given his 50% organic disability and Category III non-organic disability. However, a significant portion of his non-organic disability did not result from his compensable injury. The worker had a history of psychiatric difficulties that preceded and paralleled the physical difficulties caused by the worker's compensable injury. These non-compensable factors led to the worker's suicide attempts which exacerbated the impact of the compensable disability.

Both the compensable injury and non-compensable psychological factor contributed to the worker's overall disability. The contribution of the non-compensable factor was sufficiently significant to require apportionment under the Board policy. In fact, the majority of the non-organic disability

resulted from the worker's non-compensable suicide attempt and not from his compensable disability. The 65% pension award was confirmed.

The appeal was dismissed. [14 pages]

PDCON:
TYPE:
DIST:
DECON: Decision No. 79/87 (1987), 6 W.C.A.T.R. 104 consd;
Decision No. 1015/89 consd
IDATE:
HDATE: 270591
TCO:
KEYPER:J. Walsh, Office of the Worker Adviser
XREF:
COMMENTS:
TEXT:

WORKERS' COMPENSATION APPEALS TRIBUNAL

DECISION NO. 383/91

This appeal was heard in Toronto on May 27, 1991, by a Tribunal Panel consisting of:

J.P. Moore : Vice-Chair,
D.B. Beattie : Member representative of workers,
G.M. Nipshagen: Member representative of employers.

Submissions were completed on August 20, 1992.

THE APPEAL PROCEEDINGS

The worker appeals the decision of the Hearings Officer, J. Davies, dated January 26, 1990. The worker appeared and was represented by J. Walsh, of the Office of the Worker Adviser.

THE EVIDENCE

The following were marked as exhibits:

Exhibit #1: Case Description materials prepared by the Tribunal Counsel Office;

Exhibit #2: Case Description Addendum #1;

Exhibit #3: a letter prepared by the Tribunal Counsel Office, dated March 9, 1992;

Exhibit #4: a medical report from Dr. A. Margulies, dated June 11, 1992.

The worker testified under oath. Mr. Walsh made submissions at the hearing of the worker's appeal and prepared post-hearing written submissions.

THE NATURE OF THE CASE

The worker injured his back in an accident at work on May 28, 1962. The worker received various temporary disability benefits until September 30, 1964, when he was granted a 10% permanent partial disability award for a low back disability. The permanent award was increased several times over the ensuing years. After being granted a 50% permanent disability award on July 6, 1987, the worker appealed. His appeal was denied by the Decision Review Branch on June 9, 1988. However, the Hearings Officer, in the decision noted above, increased the worker's permanent award to 65%. The worker appeals the Hearings Officer's decision to the Tribunal.

The issue before the Panel is whether the worker's 65% permanent partial disability award adequately reflects the usual impairment of earning capacity resulting from the worker's compensable injury.

THE PANEL'S REASONS

(i) The history of the worker's disability

At the time of the hearing of this appeal, the worker was 61 years of age. He injured his lower back on May 28, 1962, while lifting a heavy case. Following this accident the worker began to experience persistent back pain which has never resolved itself.

Interspersed with this history of ongoing back pain is a history of emotional disability that first became apparent when the worker was 19 years of age and attempted suicide. The worker's recent medical history includes two further attempts at suicide.

The worker has had only sporadic treatment for his psychological problems. To enable the Panel to have a better understanding of the worker's psychological status, the Panel requested and obtained a comprehensive medical report from Dr. A. Margulies, a psychiatrist, and one of the Tribunal's medical assessors. Dr. Margulies' report was based on his review of the worker's file; his opinions are discussed in greater detail below. In detailing the history of the worker's ongoing disability, occasional reference will be made to excerpts from Dr. Margulies' report.

Dr. Margulies summarized his perception of the worker's early psychiatric difficulties in the following terms:

> Nothing further is known of the sequelae of this incident [the suicide attempt at age 19] or of his subsequent psychological functioning until 1960 when he was 29 years of age and admitted to Toronto Western Hospital... diagnosed as having an "immature schizoid personality". He was treated with electro-convulsive therapy (ECT) with unclear results but when seen for psychiatric assessment by Dr. J.P. Grant in November of 1962, approximately six months following his compensable back injury, "evidence of a schizoid personality with episodes of frank paranoidal and schizophrenic thinking" were noted. He was also noted at that time to have assumed his own unique and personal religious philosophy and to have undertaken a "solitary existence". Mention is also noted in the medical documentation of an admission for psychiatric treatment for unstated reasons to Toronto Western Hospital during the summer of 1964 when he again underwent a course of ECT with unknown results.

During the course of the events described by Dr. Margulies, the worker suffered his injury at work. As we noted above, the worker received extensive compensation benefits following the accident. He underwent surgery on his back in 1962 or 1963. The materials in the Board file begin, at this point,

to refer to a "psychogenic component" in the worker's ongoing disability. There appears to have been some resistance to accepting fully the worker's claim because of a perception of a significant pre-existing psychological condition.

Eventually, the worker obtained retraining, under the auspices of the Board, and obtained a position as a sales representative for an automobile dealership. He remarried, had two children, and seems to have settled down into a life that he described in his testimony as fairly happy. During this time, the worker received a 10% permanent partial disability award for his low back. In 1968, the worker's permanent award was increased to 15%.

Except for an interval between 1978 and 1980, when the worker was seeking coverage for prescription drugs, there was virtually no involvement on the part of the Board with the worker between 1970 and 1984. And with the exception of two reports in 1978, there are no medical reports in the Board file pertaining to the worker's back condition between 1971 and 1984.

The two reports in 1978 were prepared by Dr. D. Simmonds, an orthopaedic surgeon. The first, dated September 5, 1978, indicated that the worker had fallen from a ladder some two months earlier injuring his low back. The report refers to a "long history of lumbar spine problems stemming back to 1962". The report also indicates that the worker was unable to work as a result of his back condition.

Shortly before seeing Dr. Simmonds, the worker had met with a Board representative, on August 14, 1978, at which time he mentioned that he had recently been laid off because his ongoing back disability had caused him to miss too much work. It was not clear, however, from the interview that the worker claimed temporary benefits. Subsequent memos suggest that the worker simply claimed reimbursement for prescription drugs.

A follow-up report by Dr. Simmonds, dated December 4, 1978, indicates continuing pain but makes no reference to whether or not the worker returned to work.

It would appear however, that the worker did manage to get back to work since the worker was employed when he next contacted the Board. This occurred in early 1984. At that time, the worker stated that his back condition was worsening and he requested further coverage for prescription drugs. In February 1984, the worker began receiving regular medical treatments for low back pain.

Some time in late 1984, the worker stopped work and claimed temporary disability benefits. From this point onward, the worker's overall condition began to deteriorate dramatically. On May 27, 1985, his permanent disability award was increased to 20%. The examination giving rise to the increase made reference to signs of "pain magnification". The worker was, by this time, beginning to show symptoms of serious neurological deficit secondary to his back injury. We note the following summary of the worker's organic disability from a report prepared by Dr. M. Bernstein, neurosurgeon, on August 26, 1985:

> In summary, this gentleman has a new pain in his right foot 25 years after two back operations and he has

> neurological signs of involvement of the right L5 nerve root. Evidently his CT scan demonstrates significant spinal stenosis.

Coupled with the deterioration of his back condition, was the deterioration of the worker's marriage. According to the worker, he decided, in 1984 or 1985, to sell his house and invest the proceeds in a business. This decision was the precipitating factor in the breakdown of his marriage. Legal action ensued in which the worker got custody of his two children. Following the resolution of his divorce proceedings, the worker purchased another house which he shared with his two sons. These events took place in 1985 and 1986.

In August 1986, according to the worker, he was involved in an automobile accident. There did not seem to be any reference to this accident in the Board file materials of that time. Although there is no indication of this in the file, the worker testified that he went through the windshield of his car during the accident of August 1986. In October 1986, the medical reports begin to refer to seizures, stress, as well as uncontrolled back pain. The worker was not able to provide the Panel with any additional information concerning the automobile accident of 1986.

In January 1987, the worker attempted to take his life by ingesting antifreeze. This led to "multisystem failure" and a coma lasting two and a half weeks. The medical evidence subsequent to this event suggests that the worker may have suffered significant neuropsychological damage as a result of the ingestion of this poison.

Some time in the summer of 1987 the worker made a second attempt at suicide by ingesting Valium.

According to Dr. Margulies' interpretation of events, the worker's suicide attempts had been proceeded by several months of essentially depressive symptoms which were attributed by the worker to the motor vehicle accident of August 1986. Following the suicide attempts, the worker received no further psychiatric treatment.

On July 6, 1987, the worker's permanent disability award for his low back was increased to 50%. The examination giving rise to the report refers essentially to organic symptoms of back pain accompanied by significant neurological deficit. There is, however, a reference to the worker's emotional problems as "the predominant factor" at the present time. It is not clear from the assessment whether the 50% award was intended to cover the non-organic aspect of the worker's disability.

There is no indication of any medical treatment of the worker's low back subsequent to 1987. The worker testified that he has since moved to Florida where he either stays with friends or sleeps in his car. The worker testified that he continues to experience significant pain in his back and in his legs as well as some difficulties with his lungs that resulted from non-compensable factors. He stated that his last medical examination prior to the suicide attempts in 1987 was in December 1986.

The worker was of the view that he was 100% disabled as a result of his organic low back condition. Mr. Walsh argued, on behalf of the worker, that regardless of the nature of the worker's disability, he was 100% disabled, as a whole person. Mr. Walsh further argued that the worker's disability, including the disability associated with his suicide attempts, resulted from his compensable back injury. In Mr. Walsh's submission, it was the deterioration of his back that led to the break-up of his marriage and the subsequent suicide attempts. Mr. Walsh submitted that the worker should be granted a 100% permanent disability award in recognition of his impairment of earning capacity.

(ii) The medical evidence

The last assessment of the extent of the worker's organic disability is contained in the assessment giving rise to his 50% permanent disability award. That assessment, performed by Dr. J. Ritchie, a Board Consultant, on July 6, 1987, noted extreme tenderness in the worker's back with a lot of muscle spasm. The worker demonstrated severe limitation in his movements and was unable to stand erect. The right thigh was smaller than the left and showed no reflexes. There was marked weakness in the right leg and the worker was incapable of straightening that leg. Finally, Dr. Ritchie noted that the worker had "a definite drop foot" on the right side.

The worker's psychological status is described in psychological consultation reports prepared at the Toronto General Hospital when the worker was hospitalized following his suicide attempts. The last such report contains the following summary:

> Neuropsychological profile of this 57 year old gentleman who is hospitalized for his second suicide attempt this year is one of poor attention and concentration, significant memory impairment, and severe psychomotor slowing and uncoordination. Such a profile is compatible with reversible dementia due to vitamin deficiency or to long term consequences of the ethylene glycol intoxication exacerbated by the recent Valium overdose.

That report was prepared by Dr. J. Ridgley, a clinical psychologist. In another report, prepared by Dr. S. Kennedy, a staff psychiatrist at Toronto General Hospital, is found the following summary:

> On January 8, 1987 [the worker] took an overdose of ethylene glycol antifreeze and weed killer. He described a severe and progressive depression starting in August 1986 after a car accident which caused a loss of consciousness and subsequent seizures. He described increased social isolation, chronic pain syndrome secondary to lumbar spinal stenosis with an associated dependence on narcotics. He also described decrease in self esteem, secondary to early retirement approximately five years ago because of his chronic pain. In addition he was divorced from his wife shortly after his retirement, and claims that this has contributed to his feeling of isolation.

Dr. Margulies, in his report, attempted to summarize the scattered medical evidence concerning the worker's psychological state. We note the following excerpts from his report.

> Despite the voluminous nature of [the worker's] WCB file, his psychiatric state is, in this observer's opinion, poorly documented. ...Notwithstanding and taking into consideration the 1962 observations of Dr. Grant and Dr. A.J. Preston, who also assessed the injured worker, it is reasonable to assume that [the worker] likely suffered from a lifelong severe personality disorder which, by today's standards, would be considered a schizotypal type and that he had likely had episodes of decompensation with frank but transient psychotic symptoms.
>
> Assuming the accuracy of such a diagnosis, the particular ideation and bizarre notions attributed to [the worker] and which were manifestations of this lifelong personality pattern came into play with respect to his compensable injury. In other words, his pre-existing psychiatric condition affected his reactions and responses to his compensable injury and as his pain persisted despite operative intervention, [the worker] by no means surprisingly became increasingly focused upon his physical injuries in his pre-existing bizarre and thought disordered manner....
>
> Much to his credit and with the assistance of a retraining program, [the worker] found employment as a car salesman and remarried in the mid-1960's. His subsequent course is by no means clear until the mid-1980's when he apparently showed rather poor judgment with impulsive behaviour, selling his home, and unsoundly investing the proceeds and eventually seeing his marriage break up. Around the same time, his low back pain intensified. In retrospect, it appears that for unclear reasons which likely were induced from within, [the worker's] emotional state significantly decompensated but remained unrecognized and eventually resulted in the development of what were likely major depressive symptoms and the bizarre suicide attempts of January 1987. Notwithstanding his belief to the contrary, there is little reason to suspect that the motor vehicle accident of August 1986 played a significant role in his psychological decline which clearly had begun prior to that time. By the same token, the variable persistence of his painful symptoms which had been present for so many previous years cannot be implicated as the cause of his emotional deterioration.

Dr. Margulies concluded his report as follows:

> Overall, [the worker] still remains the same characterologically disturbed individual he has always

> been prone to psychotic episodes which may or may not have any external precipitating factors. On the basis of my review of the available medical documentation, I can find little indication that his emotional state has been significantly worsened by reason of the compensable injury of 1962 and its sequelae. To the contrary, his pre-existing emotional state has clearly affected his perception of pain and disability and eventually deteriorated to the point where he has been left with some degree of organic brain damage. I have great difficulty in attributing his psychological decompensation which culminated in the bizarre suicide attempt of January 1987 to the fact that his low back pain had worsened some months earlier, particularly in view of the likelihood that he was already starting to emotionally break down prior to lumbar pain intensification. There can be little doubt but that this man has had and continues to have major psychiatric problems but they cannot be attributed to his compensable injury or to any of the motor vehicle accidents in which he was involved. They clearly were present a long time prior to any of these and have continued to be manifest in a typically variable, up and down course with exacerbations and remissions.

(iii) The Panel's conclusions

In the Panel's opinion the worker's impairment of earning capacity in this case is virtually total. The permanent disability assessment performed by Dr. Ritchie, on July 6, 1987, noted extensive organic symptoms affecting the worker's back, legs and right foot. Dr. Ritchie's assessment of the impairment of earning capacity from an organic point of view was 50%.

However, in addition to the worker's organic disability, there is, in our opinion, a substantial psychiatric disability. In fact, the Hearings Officer recognized this disability and granted entitlement to the worker on that basis.

In assessing the impairment of earning capacity associated with this disability, the Hearings Officer noted the worker's significant "pre-accident history of non-organic disability", found that the worker fell within Category II of the Board's Psychotraumatic and Behavioural Disorders Rating Schedule, and assessed an award of 15% for the non-organic disability.

In the Panel's view, the 65% overall award granted to the worker was correct. However, in our opinion, it is important to emphasize the process whereby this figure is arrived at.

The Board's whole person approach requires that all aspects of a worker's impairment of earning capacity be considered as a first step in determining a worker's entitlement to a permanent disability award. Once the full extent of the impairment of earning capacity is determined, Board policy apportions the overall assessment to determine the proportion of disability attributable to the compensable factors in the worker's overall disability.

We note the following excerpt from the Tribunal's Decision No. 1015/89, July 8, 1991), which discussed this process at pages 15 and 16 of the decision:

> The complexity of apportioning in this manner, where a psychiatric disability is in issue, was highlighted in the dissent found in Decision No. 1041/89 (June 1, 1990). The dissenting Panel member stated, at page two:
>
> > To me the problem lies in the fact that a psychotraumatic disability is, by its very nature, a supremely subjective condition. There appears to be no way of estimating the impairment of earning capacity, based on the nature and degree of the injury, because the nature and degree of the injury will vary depending upon a host of other factors....
>
> On the other hand, it is fair to say that the Board's categories for estimating impairment of earning capacity in a psychiatric case appear to allow consideration of the subjective effects of the compensable injury on the worker. Symptoms such as anxiety, depression, stress tolerance, and social withdrawal have a significant subjective element that clearly is part of "the nature and degree of the injury" and hence are to be treated as part of the impairment of earning capacity.
>
> In the end, permanent disability assessments of psychotraumatic disabilities will always have to be based on roughly measurable medical standards that look at the nature and degree of the injury in question and this includes a consideration of the objective and subjective impact on an average unskilled worker with a similar disability. The necessity of using this approach was made plain in the Tribunal's Decision No. 915 (1987), 7 W.C.A.T.R. 1 (see page 81ff.). In our view, and in the view of the Board's General Counsel, the Board's rating categories are intended to address the subjective features of a worker's psychological disability in determining the degree of the impairment of earning capacity.
>
> Having said that, however, there are some subjective features which are not considered in a pension assessment because compensating for them would amount to compensating for non-compensable factors. The Board's approach in such cases is to apportion the disability, where non-compensable factors are severable, and their effect is sufficiently measurable that it is possible to quantify their contribution to the overall disability.
>
> We note the following excerpt from the Board's Claims Adjudication Branch Procedures Manual, Document #33-02-20:

> 6. Where the compensable and pre-accident or unrelated conditions are all contributing to the ongoing disability, continuing compensation benefits will be paid, commensurate with the degree of remaining compensable disability. (emphasis added)
>
> However, in our view, the severing of non-compensable factors is appropriate only where their contribution to the worker's disability can be seen, in effect, as a non-compensable cause. That would require, in our opinion, that there be a demonstrable worsening of the worker's disability and a demonstrable and significant contribution from a non-compensable factor. In other words, the significance of the contribution of the non-compensable factors would have to be such that it could be said that the original injury played a minimal role in the worsening of the worker's disability.
>
> (emphasis added)

In the present case, the Panel is of the opinion that, while the worker's impairment of earning capacity, as a whole person, was virtually total, significant contributions to the worsening of the worker's disability were made by non-compensable factors.

Concerning the extent of the worker's overall disability, we note that Category III of the Board's Psychotraumatic and Behavioural Disorders Rating Schedule reads as follows:

> In this Category the worker displays a severe anxiety state, definite deterioration in family adjustment, incipient break-down of social integration, and longer episodes of depression. The worker tends to withdraw from the family, develops severe noise intolerance and a significant diminished stress tolerance. A phobic pattern or conversion reaction will surface with some bizarre behaviour, a tendency to avoid anxiety creating situations, with every day activities restricted to such an extent that the worker may be homebound or even roombound at frequent intervals.

As we review the medical evidence in this case, and taking into account the worker's testimony, we are of the view that the worker falls within this category. The evidence established that the worker demonstrated frequent periods of severe anxiety accompanied by a significant deterioration in his social and familial relations. The evidence also established severe depression resulting in two suicide attempts. The worker's description of his lifestyle establishes, to our satisfaction, that the worker has some limited social interaction but has clearly adopted a life designed to avoid "anxiety creating situations".

By way of contrast, Category IV speaks of symptoms that demonstrate "a chronic and severe limitation of adaptation and function". Category IV identifies incapacity for self-care and personal hygiene, uncontrolled

outbursts of temper, and outstanding features of psychomotor retardation and psychological regression as typical Category IV symptoms. In the Panel's view, the worker's symptoms are not that severe.

Consequently, we conclude that the appropriate category for the worker's psychiatric disability is Category III.

In determining the appropriate overall level of impairment of the worker's earning capacity, we note that the evidence fairly clearly establishes that the combined effect of the worker's organic and non-organic disabilities is to render him virtually incapable of working. We conclude that the overall level of impairment of the worker's earning capacity is 100%, given the worker's 50% organic disability and Category III non-organic disability.

Having so concluded, however, we are also of the opinion that a significant portion of the worker's non-organic disability did not result from his compensable injury or the sequelae of that injury. As the medical evidence establishes, the worker had a significant history of psychiatric disorder prior to and at the time of his compensable accident in 1962. The medical evidence also establishes that both conditions - the compensable organic disability and the non-compensable non-organic disability - were reasonably stable for a number of years.

In approximately 1983 or 1984, according to Dr. Margulies' perception of events, both the organic and the non-organic conditions flared-up. Dr. Margulies concedes that there was some relationship between the two in that the worker "became increasingly focused on his physical injuries in his pre-existing bizarre and thought disordered manner". In the Panel's view that sort of relationship between a pre-existing non-compensable factor and a compensable organic injury does not preclude entitlement for the resulting overall disability. To put it tersely, the "thin skull doctrine" justifies entitlement for a worker whose pre-existing psychiatric instability exacerbates the effects of a compensable injury.

On the other hand, the Act directs that compensation be allowed only for a disability that results from a compensable injury. The Act anticipates allocation of cause in such circumstances and the Board has developed policies to assist it in apportioning permanent disability awards in cases, such as this, where both compensable and non-compensable factors are contributing to a disability.

We note the following discussion from the Tribunal's Decision No. 79/87, 6 WCATR 104, at page 111:

> The Panel considered the concept of contributing causes which arise after the accident.... Contributing causes that arise before the accident, are essentially part of the principle that the compensation system "takes the victim as it finds her". However, when things arise after the accident, it can truly be said that the system is not required to take the victim as she becomes, unless the compensable injury caused the future problem. Accordingly, both in the courts and in Decision No. 915

> (7WCATR1), the amount of the disability attributable to the accident is reduced by the causal factor estimated to be due to the subsequent non-work related injury. It will be noted that this is to be distinguished from a recurrence of a condition caused by the compensable accident in a non-work situation. The classic example of that is a person who does a trivial movement at home and reactivates a condition caused by the work. In that case, the chain of causation has not been broken by an intervening subsequent event as in the case of a subsequent motor vehicle accident.

In the present case, the evidence in general, and Dr. Margulies' report in particular, identify other factors in the worker's life which are clearly distinct from his compensable injury which have themselves exacerbated the overall impact of the worker's disability. The medical evidence has revealed that the worker had a history of psychological difficulty that preceded and paralleled the physical difficulties caused by the worker's compensable injury. In Dr. Margulies' opinion, these factors ultimately led to the worker's unsuccessful suicide attempts. These unsuccessful suicide attempts, in turn, significantly exacerbated the impact of the worker's compensable disability.

Board policy on apportionment requires that there be "a demonstrable and significant contribution from a non-compensable factor". In the view of the Panel, the significance of the contribution of a non-compensable factor has been demonstrated in this case.

The effect of the worker's suicide attempts has been to substantially worsen the worker's overall disability. In Dr. Margulies' opinion, the worker's physical disability played a small role in the worker's suicide attempts. In Dr. Margulies' opinion, the worker's suicide attempts were the result of a lifelong history of psychological difficulty which paralleled the worker's physical disability and exacerbated its impact.

Hence, both the compensable injury and the non-compensable psychological factor contributed to the worker's overall disability.

On the strength of that analysis, we are of the opinion that the 65% assessment by the Hearings Officer of the degree of impairment of the worker's earning capacity is accurate. In our view, although the worker is effectively totally disabled, a substantial portion of that overall disability can be attributed to non-compensable factors that have no relation to the worker's compensable injury. These factors appear to have co-existed with the worker's compensable disability and seemed to have grown worse as the worker's organic disability grew worse. And, to some extent, there was a connection between the non-compensable factors and the compensable factor sufficient to warrant a conclusion that a portion of the worker's non-organic disability was compensable. However, in our opinion, the majority of the non-organic disability resulted from his non-compensable suicide attempt and not from the worker's compensable disability and, in our opinion, the Hearings Officer's assessment of the impairment of earning capacity resulting from the worker's compensable injury was accurate.

Consequently, we confirm the 65% permanent disability award granted to the worker by the Hearings Officer.

THE DECISION

The worker's appeal is denied.

DATED at Toronto, this 13th day of November, 1992.

SIGNED: J.P. Moore, D.B. Beattie, G.M. Nipshagen