WORKPLACE SAFETY AND INSURANCE APPEALS TRIBUNAL

DECISION NO. 174/11

BEFORE:	R. Nairn : Vice-Chair
HEARING:	January 24, 2011, at Hamilton Oral Post-hearing activity completed on November 3, 2011
DATE OF DECISION:	March 2, 2012
NEUTRAL CITATION:	2012 ONWSIAT 476
DECISIONS UNDER APPEAL:	WSIB Appeals Resolution Officer (ARO) decisions dated February 6, 2006 and January 21, 2010
APPEARANCES:	
For the worker:	Mr. M. Lawrence, Paralegal
For the employer:	Did not participate
Interpreter:	N/A

REASONS

(i) Introduction

[1] The following background information, contained in Tribunal *Decision No. 174/11I*, is provided in order to place this matter into proper context:

- At the time of the accident under consideration here, the worker, born in 1976, was employed as a "locator" in the employer's utility construction business. She had been hired by the accident employer in May 2001. The worker is left hand dominant.
- Memo #2 dated January 2, 2002, provides the following description of the events on June 21, 2001:

  > (…) She was out of her vehicle and locating a cable with a location machine. Her miche net went off in the car and she went to turn around. She had the locator machine in her right hand and as she turned around it pulled her arm back and her right shoulder popped out of joint.

- The Physician's First Report of December 12, 2001, provided a diagnosis of "R shoulder strain".
- Information contained in Memo #2 suggests that the worker performed modified duties for about two months as of June 22, 2001 and returned to her regular duties, using her left arm, around the end of August or the beginning of September 2001. The Claims Adjudicator also noted that "her right shoulder has popped out two times since the incident. It was not a complete separation. It popped out while she was sleeping". The Claims Adjudicator noted that the worker was laid off on December 7, 2001 and was performing her regular duties with accommodations at that time. Two other people were laid off as well and the worker advised the Claims Adjudicator that she agreed "she has been laid off work due to an employment situation and not because of her impairment".
- The WSIB (the "Board") recognized the worker's right shoulder condition as compensable.
- On January 24, 2002, Dr. J. Corless performed a "putti-platt repair" on the worker's right shoulder. The post-operative diagnosis was "recurrent subluxation of right shoulder". The Board recognized this surgery as compensable and granted the worker loss of earnings ("LOE") benefits thereafter.
- Subsequently, the Board also recognized that the worker had a permanent impairment in her right shoulder which left her with restrictions (as noted in Memo #29 of June 25, 2002) of "no repetitive right shoulder movement; lifting limitations; above shoulder activity; avoid repetitive use of the right upper extremity against resistance".
- As noted in Memo #37 of August 20, 2002, the Board determined that the accident employer would be unable to provide the worker with suitably modified duties and therefore granted her Labour Market Re-entry ("LMR") assistance and LOE benefits. An LMR assessment was conducted and in a report dated December 13, 2002, the service provider recommended a Suitable Employment or Business ("SEB") of "cardiology technologist". As indicated in Memo #45, an LMR plan was subsequently developed which envisaged the worker participating in academic upgrading from January 6 to

February 21, 2003 and then enrolling in a cardiovascular technician program course at Career Canada College which was to last until about September 2003.

- In a decision dated March 12, 2003, the worker was advised that she was being granted a 14% Non-Economic Loss ("NEL") award for her compensable right shoulder condition.
- The worker completed the academic portion of her LMR plan and received her diploma. She was not however, able to complete the special work placement which was to have run from October 6 to December 1, 2003. The decision on appeal notes that this was due "to the placement provider's concerns with liability insurance, then delays in obtaining [the worker's] transcripts from the training facility and, finally, the birth of her son on May 5, 2004".
- In Memo #65 dated May 11, 2004, the Claims Adjudicator noted the following after a conversation with the worker:
    - She had her baby on May 5, 2004.
    - She did not get her job placement yet and was waiting for this for so long.
    - I told her that I have to close her file at this time.
    - She indicates that if we had given her job placement a long time ago she would have been able to qualify for employment insurance.
    - But since she has not been working she has not been able to look for employment.
    - I told her that I am going to close her file.
    - I feel that she has obtained the skills to look for work in the SEB selected once she is ready.
    - I do not feel that she really needs the job placement in order to find employment.
    - She indicates that she would like to spend six months with her child and then may want to start the job placement if it is ready at that point.
    - I advised her that I'm not sure if I can approve that but I will review it.
- In a decision dated May 26, 2004, the Claims Adjudicator confirmed:

    (…)

    Since you are no longer able to participate in the LMR program your loss of earnings benefits have been closed as of May 5, 2004.

    As your LMR file has been closed, you have been provided with the necessary skills and ability to enter the workforce in the suitable employment or business of "cardiology technologist". Average entry earnings for this occupation is $16.93 per hour, which exceeds your pre-injury earnings, therefore, you will not be suffering a wage loss.

- The worker objected to the Board's position on the suitability of her SEB and their decision to terminate her LOE benefits effective May 5, 2004. These issues were eventually forwarded to an Appeals Resolution Officer ("ARO") and in a decision dated February 6, 2006, the ARO denied the worker's appeal and concluded:

    I reviewed the file documentation in detail having regard for the submissions and arguments tendered as well as the relevant WSIB policies. In my analysis, I concurred with the determinations made that [the worker] successfully completed her LMR plan and was competitively employable in the SEB agreed at a fully restored earnings capacity.

- The worker, who did not return to work, gave birth to her second child in September 2005.
- On August 25, 2006, the worker had further surgery performed on her shoulder, this time by Dr. J. Theodoropoulos. The orthopaedic surgeon performed a "1. right shoulder arthroscopy, 2. right shoulder capsular plication and 3. right shoulder subacromial decompression". This surgery was recognized as compensable by the Board and LOE benefits were reinstated.
- Information on file suggests that in late 2008, the worker requested that she be granted entitlement to benefits for a psychotraumatic/bipolar disorder which she claimed could be causally related to her compensable accident and its sequalae. In Memo #139 dated February 10, 2009, the Claims Adjudicator noted:

  > The worker rep has written in a letter dated 06 Feb 2009 and has requested entitlement to bipolar/psychological disorder secondary to the workplace injury.
  >
  > This worker has a 14% NEL for a right shoulder injury.
  >
  > Worker had two surgeries to the left shoulder. 24 Jan 2002 she had a patty plat repair. On 25 Aug 2006 she had an arthroscopy done.
  >
  > The surgeries performed would not be considered terribly invasive or disabling.
  >
  > The condition of bipolar disorder would not be considered work-related at this time and in order to consider the psychological condition a dx of such would be required.
  >
  > I will deny the worker's rep request at this time.

- Subsequently, the worker asked that she be granted entitlement to benefits for Chronic Pain Disability ("CPD") which she claimed could be causally related to her compensable accident and its sequalae. In the course of considering the worker's request, the Claims Adjudicator asked for a medical opinion and in Memo #143 dated September 23, 2009, Dr. Craven of the Board concluded:

  > (…)
  >
  > The sudden severe increase in pain and change in active range of motion in early October 2008 would likely have been due to an organic cause. This pattern of change in pain is not consistent with a chronic pain syndrome.
  >
  > Consideration on the basis of chronic pain disability would not be appropriate with the information currently on file.

[18] The worker objected to the Board's decision to deny her entitlement for psychotraumatic or CPD conditions and these issues were forwarded to another ARO. In a decision dated January 21, 2010, the ARO denied the worker's appeal and with respect to the issue of a psychotraumatic disability, noted in part:

> (…) From what we do know, the condition became manifest in December 2007. The original injury was June 21, 2001. The policy with respect to psychotraumatic disability states that the condition must become manifest within five years of either the accident or the last surgery. The last surgery in this case would have been August 25, 2006. However, one cannot ignore the fact that bipolar disorder is not a condition which is compatible to the accident history here or the sequelae. The worker and her representative have provided no evidence in order to establish a causal link between the onset of this disability, often known to be hereditary, and the accident and the sequelae. We know there was no organic brain injury at the time of the original accident. There was no physical injury to the brain. A relationship between bipolar disorder and the extended disablement has not been shown. Based on my review of the evidence, I find that there is

> insufficient evidence to support that this psychotraumatic disability should be accepted as part of entitlement under this claim.

- The ARO also denied the worker initial entitlement to benefits for CPD and in doing so, concluded that the pain the worker experienced was not inconsistent with the organic findings in her case and added:

> It should be pointed out that this worker has had two surgeries under this claim but has had several other stressors going on in her life since this accident occurred. According to the record, she has had five pregnancies, two resulting in live births in May 2004 and September 2005. It should be noted that she is left-handed. Early medical information shows that there may have been a thyroid disability, hypertension and a stroke on February 21, 2003. The worker has undergone gynaecological surgery and injuries to both of her knees, including surgery on her right knee. It appears she has had a lot going on in the last few years and I do not find that the right shoulder surgeries were a significant contributory factor to her development of chronic pain disability and/or bipolar disorder.

[2] The worker appealed the ARO decisions of February 6, 2006 and January 21, 2010 to the Tribunal and a hearing was held on January 24, 2011. At that time, oral testimony was provided by the worker and submissions were made by Mr. Lawrence. As noted in *Decision No. 174/11I*, the issues to be determined at that time were:

> (a) whether the worker ought to be granted initial entitlement to benefits for a psychotraumatic condition (bipolar disorder) or CPD which she claims can be causally related to the compensable accident and its sequalae; and
>
> (b) whether the SEB of "cardiology technologist" was suitable for this worker's restrictions and whether she has ongoing entitlement to LOE benefits after May 5, 2004.

[3] After considering the evidence and submissions provided at the hearing on January 24, 2011, I issued *Decision No. 174/11I* dated May 10, 2011, in which I decided that this would be an appropriate case in which to seek the assistance of a Tribunal Assessor on the issue of psychotraumatic entitlement. With respect to this issue, I noted:

> (iv) **Analysis**
>
> (a) Psychotraumatic entitlement
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> [34] As noted earlier in this decision, the worker has requested that she be granted entitlement to a psychotraumatic disability (bipolar disorder) which she claims can be causally related to her compensable accident and its sequalae. As Mr. Lawrence acknowledged in his submissions, the issue of a bipolar disorder appears to have first arisen in an emergency department report covering a visit by the worker on October 12, 2008. The emergency staff listed the worker's "past medical history" as "bipolar, rotator cuff 02". It was the worker's testimony that her family physician had felt for some time, that the symptoms of anxiety and depression she was experiencing might be the result of a bipolar condition.
>
> [35] The ARO, in her decision of January 21, 2010, denied the worker entitlement to benefits with respect to the bipolar disorder and noted in part:
>
> > (…) However, one cannot ignore the fact that bipolar disorder is not a condition which is compatible to the accident history here or the sequelae. The worker and her representative have provided no evidence in order to establish a causal link between the onset of this disability, often known to be hereditary, and the accident and the sequelae. (…)

> [36] What was not available to the ARO, and which has been marked as Exhibit #8 at this hearing, is a January 19, 2011, report from Dr. A. Amaladoss, (a psychiatrist) which provides an Axis I diagnosis of "bipolar disorder NOS; recurrent panic anxiety; social anxiety with agoraphobic tendency; query ADHD". Dr. Amaladoss also notes that "this is probably related to her chronic pain from her work injury and her pain medications".

[4] In *Decision No. 174/11I*, I listed a number of questions for the Assessor to answer with respect to the issue of psychotraumatic entitlement. In the course of arranging to select an appropriate Assessor, the Tribunal's Medical Liaison Office ("MLO") suggested some amendments to the questions posed.

[5] By means of an e-mail dated July 15, 2011, I advised the Tribunal Counsel Office ("TCO") and MLO that I had no objection to the proposed amendments, and in a letter dated August 11, 2011, (contained in Post-Hearing Addendum No. 1), the Assessor was asked to respond to the following questions:

1. On the basis of your review of this case, and any examination that you feel necessary, please provide your DSM-IV diagnoses, both the preferred and the differential diagnoses, and give the reasons for each.

2. Please comment on any relationship between the workplace accident on June 21, 2001 and/or its sequelae, as described by the Vice-Chair in his findings of fact, and the worker's psychiatric condition.

   (a) Would the workplace accident and/or its sequelae have caused or contributed to the development of the worker's psychiatric condition?

   (b) Is this medically likely? Please explain.

3. Is there medical evidence to suggest a pre-disposition to the worker's psychiatric condition? If so, to what degree has it affected the worker's current condition?

4. Please comment on any other factors which may have contributed to the onset of the worker's psychiatric condition.

   (a) Are there any other factors that may have contributed to the ongoing condition?

5. there any other information which you believe would be of assistance to the Vice-Chair or parties in adjudicating this appeal?

[6] Subsequently, Mr. Lawrence also forwarded a copy of a July 28, 2011 MRI of the worker's right shoulder. I agreed to Mr. Lawrence's request that this report be sent along to the Assessor.

(ii) The Tribunal Assessor

[7] As requested in *Decision No. 174/11I*, the MLO selected Dr. A. Margulies as the Tribunal Assessor in this case. Dr. Margulies is a psychiatrist and currently an Adjunct Assistant Professor at the Department of Psychiatry at the University of Toronto.

[8] In his report of September 15, 2011, Dr. Margulies indicated in part:

(…)

At some point [the worker] apparently started to experience undescribed symptoms of what was said to be "anxiety" for which she was treated by her personal physician, Dr. D. Beasley. She also developed undescribed "mood swings" which, some time in the latter months of 2007, were deemed to be indicative of some sort of bipolar disorder. [The worker's] claim of an etiological relationship between her psychiatric symptoms of "anxiety" and social withdrawal, "panic attacks," and bipolar disorder and the work-related injury to her right shoulder and sequelae thereto, was dismissed. Subsequent to rejection of claim of entitlement for psychotraumatic disability, i.e. bipolar disorder, appeal has been undertaken.

In reference to the provided records, the first documented notation of any symptoms suggestive of a bipolar disorder is to be found in the clinical note of Dr. D. Beasley, family physician of [the worker], of December 5, 2007. This note, unfortunately, appears incomplete but refers to a labile and fluctuating mood with ups and downs, irritability, sleeping, eating and sexual disturbances, difficulties in concentration and disinterest, along with episodes of high energy and excess buying. While it can be said that this description is consistent with some of the symptoms of a bipolar disorder, it is insufficient to reach full criteria to confirm the diagnosis. (…)

Overall, symptoms noted probably are equivalent to the "anxiety" and "depression" attributed to [the worker] during this time, and while in keeping with, do not fulfil all criteria necessary to support a diagnosis of bipolar disorder. It can be said, therefore, that between the end of 2007 and end of 2008 [the worker] showed symptoms which may have been indicative of bipolar disorder, underwent treatment that was appropriate for bipolar disorder, and would appear to have attained some improvement.

(…)

The psychiatric report of Dr. A.S. Amaladoss, dated January 19, 2011, indicates initial referral from Dr. Beasley in July of 2010 for what was described as "unremitting mood symptoms" which were suspicious of bipolar disease. No further clinical information with respect to mood or any other symptoms which would support a diagnosis of a bipolar disorder are to be noted in the referenced report of Dr. Amaladoss in which, nonetheless, it was concluded that [the worker] was suffering from some form of bipolar disorder. It was also opined, but without explanation, that somehow or other [the worker's] "mood symptoms" had been worsened since the compensable injury in which she was involved in May of 2001. Analgesic medication, presumably opioids, were also said to have had an exacerbating effect upon the "mood symptoms" of, presumably, a bipolar disorder. Accepting the diagnosis of a bipolar disorder – and there is less than compelling evidence to support it – I am unable to find any evidence in support of the proposed notion of an exacerbation of symptoms of a suspected bipolar disorder somehow or other of being related to a compensable injury sustained more than nine years before examination by Dr. Amaladoss.

Overall, neither by history nor by clinical description is there a convincing account in the report of Dr. Amaladoss to fulfil necessary criteria to support the diagnosis of a bipolar disorder. Reference is made to a "mental status assessment", which is said to demonstrate that a bipolar disorder is present and while this may, indeed, by the case, there is no provided information which can support this.

On the basis of all provided documentation, an evidence-based psychiatric diagnosis, according to DSM-IV criteria, cannot with confidence be made. It has been reported that [the worker] does experience a bipolar disorder and on the basis of provided but fundamentally incomplete information, it is probably the likely diagnosis. A differential diagnosis would include substance abuse disorder, borderline personality disorder, or major depressive episode. (…).

> Assuming the accuracy of the diagnosis of bipolar disorder (of which there is, as noted above, much uncertainty), it is currently generally accepted that bipolar disorder is a likely biochemical disorder involving abnormalities in neurotransmission. While the cause or causes of the underlying biochemical abnormalities are not specifically known, it is recognized that there is a strong genetic/familial tendency, and while external factors, such as psychosocial stressors, pharmacological agents or physical disease, may precede the onset of a depressive or manic episode, they do not *de novo* cause episodes. Rather, they mobilize them in persons with appropriate pre-existing vulnerability. There is a close chronological relationship between a purported stressor and the development of a depressive or manic or hypomanic episode (as would be found in bipolar disorder), the period of time between stressor and decompensation being relatively brief and measured in a matter of weeks. Because the workplace accident in which [the worker] was involved occurred in June of 2001 and the first mention of any symptoms which may have been even early manifestations of a bipolar disorder was noted sometime in 2007, some six years later, there can be no etiological relationship between [the worker's] compensable injury of 2001 and her development of what may have been a bipolar disorder in 2007.
>
> It has been suggested that certain accident sequelae, such as persisting pain and associated impairments, have served as a kind of chronic stress or acting upon [the worker] and resulting in the development of a bipolar disorder. Based on current understanding of bipolar disorder and the role stress may play in it, this hypothesis is not correct. As noted above, where stress is a factor in an episode of bipolar disorder, the time frame between the purported stressor and the development of symptoms is measured in weeks. So-called chronic stress may have many effects upon an individual but precipitating a bipolar episode is not one of them.
>
> On the basis of current understanding of bipolar disorder, genetic and familial factors are considered to be strong predisposing ones to the development of the clinical manifestation of a bipolar illness. Such factors would include a history of mood disorder in family members or/and a prior history of episodes of mood disturbance. On the basis of provided documentation, there is no information whether or not inquiry had been made into such possible predisposing factors and by extension whether or not [the worker] had any predisposition to develop a mood disorder.
>
> (…)
>
> On the basis of this review, I find that there is no need for a psychiatric evaluation of [the worker] be undertaken. (…)

(iii) Submissions of the worker's representative

[9] Mr. Lawrence was provided with a copy of Dr. Margulies' report and given the opportunity to make written submissions upon it. In a letter dated October 31, 2011, Mr. Lawrence advised:

> It is evident that Dr. Margulies does not support the diagnosis of bi-polar disorder in this worker's case. It does not seem, however, that the depression, anxiety and mood swings were considered as a psychiatric condition, separate from the suspected bi-polar disorder.
>
> Much emphasis was placed on the suspected bi-polar disorder, and entitlement, (potential or not) to Psychotraumatic Disability or Chronic Pain Disability under policy was not clearly assessed or defined. Other possible diagnoses were not investigated clearly in this assessment.
>
> It is our conclusion that although a diagnosis of bi-polar disorder may not [be] in order for this worker, entitlement for a psychiatric disorder <u>is</u> in order under Chronic Pain Disability policy or Psychotraumatic Disability policy based upon the supporting medical evidence.

(iv) Issues on appeal

[10] As noted earlier, the issues to be determined in this case are:

1. Whether the worker ought to be granted initial entitlement to benefits for a psychotraumatic condition (bipolar disorder) or CPD which she claims can be causally related to the compensable accident and its sequalae; and

2. Qhether the SEB of "cardiology technologist" was suitable for this worker's restrictions and whether she has ongoing entitlement to LOE benefits after May 5, 2004.

(v) Analysis

[11] Since this worker's accident occurred in 2001, the applicable legislation is the *Workplace Safety and Insurance Act, 1997* (the "WSIA").

(a) Entitlement for a psychotraumatic condition

[12] Section 126 of the WSIA provides that the Tribunal is bound to apply applicable Board policy. In this case, the Board has advised the Tribunal that one of the applicable policies is *Operational Policy Manual* ("OPM") Document No. 15-04-02, entitled "Psychotraumatic Disability". This policy provides 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**
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> Entitlement for psychotraumatic disability may be established when the following circumstances exist or develop
>
> Organic brain syndrome secondary to
>
> - traumatic head injury
> - toxic chemicals including gases
> - hypoxic conditions, or
> - conditions related to decompression sickness.

> As an indirect result of a physical injury
>
> - emotional reaction to the accident or injury
> - severe physical disability/impairment, or
> - reaction to the treatment process.
>
> The psychotraumatic disability is shown to be related to extended disablement and to non-medical, socioeconomic factors, the majority of which can be directly and clearly related to the work-related injury.
>
> (…)

[13] Information on file reveals that in a letter dated February 6, 2009, the worker's former representative asked the Board to make a ruling "regarding the onset of bipolar disorder", indicating that "looking into case history, this condition developed by late fall of 2007. We feel the compensable condition and stressors following the injury through the years has, in fact, triggered this disorder". The former representative asked that the Board make "a ruling on psychological [ ] secondary to the workplace injury".

[14] A review of the information on file suggests that it was in early 2008 when the worker's treating practitioners began to document changes in the worker's mood. For example, in a note dated February 3, 2008, the worker's family physician noted symptoms of "up and down, continuous in one day – depressed still, not getting up, don't want to leave house, exhausted, can't sleep". In another note dated April 15, 2008, the family physician noted "mood out of control". As indicated in the decision on appeal and in Mr. Lawrence's submissions, the issue of bipolar disorder appears to have first appeared when the worker sought treatment at a local Hospital Emergency Department for neck pain in October 2008. At that time, the reporting outlined the worker's "past medical history" as "Bipolar. Rotator cuff 02."

[15] When he appeared before the Board and the Tribunal, Mr. Lawrence requested that the symptoms of bipolar disorder be recognized as compensable on the grounds they could be causally related to the worker's compensable accident. In support of that position, Mr. Lawrence relied primarily on a report dated January 19, 2011, from Dr. Amaladoss, the worker's treating psychiatrist. In that report, Dr. Amaladoss indicated in part:

> [The worker] has been under my care since the 9th of July 2010. She had been referred by her family physician with unremitting mood symptoms in spite of the various treatment combinations, suspecting bipolar disorder. (…)
>
> She is being managed with maintenance treatment. She has been seen regularly on a two to four-week basis and she is being managed with psychotropic medications, coupled with individual diadactic psychotherapy. She has been having severe pain due to the injury and she is on pain medication. The pain medication can also aggravate or exacerbate her mood symptoms and chronic pain.
>
> Her prognosis is quite guarded in view of the fact of the long duration of her condition. It seems that her mood symptoms have been aggravated since the work injury and she had been tried with various psychotropic medications by her family physician, Dr. Beasley, yet it seems to be persisting and exacerbating on a regular recurrent basis. This is probably related to her chronic pain from her work injury and her pain medications.

[16] In his report of January 19, 2011, Dr. Amaladoss provides an Axis I diagnosis of "Bipolar Disorder NOS; Recurrent Panic Anxiety; Social Anxiety with agoraphobic tendency; QDHD".

[17] While I acknowledge the comments provided by Dr. Amaladoss, I prefer to place greater evidentiary weight upon the opinion provided by the Tribunal Assessor, Dr. Margulies, who has provided more reasoning/explanation of the basis for his opinion. In his report of September 15, 2011, Dr. Margulies notes that even if one accepts the diagnosis of bipolar disorder (of which there is, as he notes, "much uncertainty"), he indicates that "it is currently generally accepted that bipolar disorder is likely a biochemical disorder involving abnormalities in neurotransmission". Dr. Margulies adds:

> While the cause or causes of the underlying biochemical abnormalities are not specifically known, it is recognized that there is a strong genetic/familial tendency, and while external factors, such as psychosocial stressors, pharmacological agents or physical disease, may precede the onset of a depressive or manic episode, they do not *de novo* cause episodes. Rather, they mobilize them in persons with appropriate pre-existing vulnerability. (…)

[18] I accept the opinion provided by Dr. Margulies that it is unlikely, given the current state of medical literature, that the worker's compensable injuries would have caused her bipolar disorder. As I understand Dr. Margulies' report, it appears that while there may be cases where a pre-existing vulnerability to bipolar disorder is aggravated by psycho-social stressors, for that to be the case however, there would need to be a close temporal relationship with the stressor. I also accept Dr. Margulies' opinion that:

> (…) There is a close chronological relationship between a purported stressor and the development of a depressive or manic or hypomanic episode (as would be found in bipolar disorder), the period of time between stressor and decompensation being relatively brief and measured in a matter of weeks. Because the workplace accident in which [the worker] was involved occurred in June of 2001 and the first mention of any symptoms which may have been even early manifestations of a bipolar disorder was noted sometime in 2007, some six years later, there can be no etiological relationship between [the worker's] compensable injury of 2001 and her development of what may have been a bipolar disorder in 2007.

[19] Dr. Margulies notes that accepting that the worker suffers from a bipolar disorder, given the passage of time between the accident and the onset of symptoms, it cannot be concluded that the accident played a significant role in the development of the bipolar disorder. Dr. Margulies concludes:

> So-called chronic stress may have many effects upon an individual but precipitating a bipolar episode is not one of them.

[20] In his post-hearing submissions, Mr. Lawrence indicates that Dr. Margulies does not support the diagnosis of a bipolar disorder in this worker's case, but suggests that her symptoms of depression, anxiety and mood swings could be recognized as some other sort of psychotraumatic condition which was causally related to the compensable accident. Up until this point in time, the worker and her representative had been consistent in their position that the worker's symptoms were related to a diagnosed bipolar disorder which was caused by the compensable accident. This position was based on the reporting provided by Dr. Amaladoss. While Dr. Margulies' report raises some questions with respect to the diagnosis, he accepts that it is the likely diagnosis, based on the available information. I have not been provided with any medical documentation supporting a new diagnosis or supporting a relationship between that new diagnosis and the compensable accident. Accordingly, based on the evidence before me, I am satisfied that the worker's likely diagnosis is bipolar disorder and that the workplace accident of 2001 did not make a significant contribution to this condition.

(b) Entitlement for CPD

[21] OPM Document No. 15-04-03, entitled "Chronic Pain Disability" provides that in order to be granted entitlement to benefits for CPD, five criteria must be established. The evidence must show:

- that a work-related injury occurred;
- that chronic pain is caused by the injury;
- that the pain persists six or more months beyond the usual healing time of the injury;
- that the degree of pain is inconsistent with organic findings, and
- that the chronic pain impairs earning capacity.

[22] Having had the opportunity to review all the material before me, I am satisfied that the balance of evidence does not support the granting of CPD entitlement. At the outset, it should be noted that I was not referred to any medical evidence which provided the diagnosis of CPD. While there are mentions of her suffering from "chronic right shoulder pain", I interpret these comments to mean ongoing or continuing right shoulder pain, rather than referring to a diagnosis of CPD.

[23] In addition to the absence of a CPD diagnosis, and the fact the worker has never been treated in any chronic pain or pain management program, the evidence indicates that the pain the worker experiences is consistent with the organic findings. The Board has recognized that this worker has a permanent impairment of her right shoulder and she has been granted a 14% NEL award to reflect that. She has undergone two bouts of surgery on her right shoulder. As indicated earlier, Mr. Lawrence provided the Tribunal with a copy of a July 28, 2011 MRI of the worker's right shoulder, the results of which were interpreted by Dr. J. O'Neill (radiologist) to reveal:

1. Full thickness tear of subscapularis with 5cm of tendon retraction and significant fatty atrophy;
2. Moderate supraspinatus tendinosis with small under surface tear of the leading edge;
3. Deficient/torn middle and anterior band inferior GHLs.

[24] In support of his request for CPD entitlement, Mr. Lawrence referred to a November 4, 2008 report from Dr. J. Theodoropoulos, an orthopedic specialist, in which he indicated:

> [The worker] had a follow-up of her shoulder instability. She did actually well for about two years and then she had an acute episode where she had some neck pain radiating into her shoulder.
>
> Actually, she definitely comes for shoulder problem but she is tender over the biceps. She has really limited active forward flexion. She can only forward flex to about 110 degrees, passively to 140 with pain, diffusely throughout the shoulder. She is on Workman's Compensation Board, and she is now just living at home and not working.
>
> Apprehension and relocation cause her pain, not relieved by relocation. O'Brien's test is painful. Speed and Yergason's are not really significantly painful. She is grossly neurovascular intact. Her neck is uncomfortable particularly with the trapezius area, medial scapular and in and around her neck.

> I reviewed her MRI and other than the tendonosis for the rotator cuff, which is expected, I do not really see any significant pathology. I think at this point, we should treat her conservatively. We will try some anti-inflammatories and if she gets relief from these, we will leave it at that. Otherwise, if she continues to be symptomatic, we can try an injection.

[25] In addition to the fact Dr. Theodoropoulos has not made any reference to CPD, I do not interpret his comments to suggest that the pain the worker is experiencing, and for which she has been granted a 14% NEL award, is inconsistent with the organic findings.

[26] My conclusions on this issue are also supported by the opinion provided by Dr. Craven of the Board who, after reviewing all of the medical information on file, concluded in Memo #143 that:

> The sudden severe increase in pain and change in active range of motion in early October 2008 would likely have been due to an organic cause. This pattern of change in pain is not consistent with a Chronic Pain Syndrome.
>
> Consideration on the basis of Chronic Pain Disability would not be appropriate with the information currently on file.

[27] While there is no dispute that the worker suffers ongoing symptoms of pain and discomfort in her right shoulder, I am satisfied that the necessary policy criteria for CPD have not been met. There is no diagnosis of CPD, nor has it been established that the pain the worker is experiencing is inconsistent with her accepted organic findings.

(c) Suitability of the SEB and ongoing LOE benefits

[28] In approximately December 2002, the Board determined that the worker would be capable of obtaining employment in the SEB of Cardiology Technician.

[29] OPM Document No. 19-03-03 entitled "Determining Suitable Employment or Business and Earnings" indicates that:

> A SEB represents a category of jobs suited to a worker's transferable skills that are safe, within the worker's functional abilities, and reduce or eliminate the loss of earnings resulting from the injury.

[30] Having had the opportunity to review the information before me and to consider the testimony provided by the worker, I am satisfied that the balance of evidence supports a conclusion that the SEB of Cardiology Technician was unsuitable, given the limitations imposed by the worker's compensable right shoulder injury.

[31] While the evidence suggests that the worker was able to satisfactorily complete the academic upgrading portion of her LMR Plan and the initial work placement, the evidence suggests that by approximately mid-2004, the worker was experiencing difficulties with her right shoulder that would make it virtually impossible for her to participate in any occupation which required frequent use of her arms. For example, in a report dated October 20, 2004, Dr. J. Corless (orthopedics) noted:

> In January 2002, I did a right Putti-Platt repair for recurrent dislocation of her shoulder.
>
> A year ago, the shoulder subluxed momentarily and then she was fine until June this year when it happened again when she rolled over in bed. Apart from these two incidents, the shoulder girdle feels weak to her and she has trouble lifting fairly heavy objects.
>
> Clinically, she has unfortunately regained all of the external rotation which the operation was designed to prevent.

> Before more surgery, she is going to have a trial at physiotherapy. (…)

[32] In a Health Professional's Report dated January 7, 2005, Dr. C. Roberts (family physician) noted that the worker's right shoulder dislocated when, while riding as a passenger in a car, she grabbed the top of a window frame to brace herself as the car turned a corner. Dr. Roberts recommended restrictions of "no above-shoulder lifting, no repetitive reaching and no lifting >5-10 lbs with right arm".

[33] Other medical reporting has commented upon the worker's continued problems with her right shoulder. These include:

- In a report dated May 2, 2005, Dr. D. Beasley (family physician) indicated:

  > She suffers from a re-injury of her right shoulder. The diagnosis is recurrent dislocation of the right shoulder.
  >
  > This recurrence has incapacitated her. She has dropped her child on occasion, she is unable to do laundry, lift groceries, change bed linens, mop floors or vacuum.
  >
  > A training program September 2003 as a Cardiology Technician was interrupted when she subluxed her right shoulder lifting a heavy patient up during her work placement. She is unable to work at chest level with her arms extended.

- In a report dated November 21, 2005, Dr. J. Harrington (orthopedics) advised:

  > [The worker] was seen in the office today. She was here for follow-up of her right shoulder. I saw her in July at which time she expressed an interest in having her shoulder re-operated on. She had surgery under Dr. Corless in 2002. She had a Putti-Platt repair. She still has recurrent instability of the shoulder. She is now quite concerned as she has two young children at home and finds it difficult to lift them and carry them with any security because there is always a feeling that the shoulder will come out of joint. (…)

- In a report dated December 22, 2005, Dr. J. Theodoropoulos (orthopedics) noted:

  > I saw [the worker]. She is a lady that has right shoulder problems. She had a dislocation back in 2002 treated by a Putti-Platt by Dr. Corless. Unfortunately, she continues to have instability in that shoulder. I am not completely clear on whether she has frankly dislocating, but it appears that her husband does need to do a traction reduction manoeuvre to pull her shoulder, and this occurs mostly in her sleep or with any overhead activity in the abducted externally rotated position. She also has pain. (…)

- In the Health Professional's Report dated January 17, 2006, Dr. Beasley noted the worker sustained further injury as "she was getting into a van, her R shoulder gave out and she fell, twisting her L knee".

- The worker underwent further surgery on her right shoulder on August 25, 2006, performed by Dr. Theodoropoulos. The Board recognized this surgery as compensable.

- In a report dated June 19, 2008, Dr. Beasley advised:

  > Please find enclosed the requested clinical notes on [the worker] since she became a patient of my practice on January 24, 2005.
  >
  > [The worker's] present diagnosis is post-surgical repair of right shoulder with scarring.
  >
  > (…)
  >
  > [The worker] is unable to work due to pain of the shoulder, as well as limited range of motion. She is unable to retrain as a Cardiovascular Technician as she is unable to assist heavier patients and is unable to raise her arm to chest level.

> As she has undergone two repairs to this injury with worsening of her pain and range of motion, I expect that her prognosis is very poor.

- Having had the opportunity to consider the worker's testimony, I am satisfied that her decision to stop pursuing the SEB of Cardiology Technologist was not due to any lack of cooperation. The reporting from the service provider suggests that the worker did her best in the academic upgrading of her LMR plan and the initial work placement. As the Progress Report of June 21, 2003 indicates, the worker managed to complete her academic upgrading, despite the effects of several non-compensable factors which included a minor stroke, a miscarriage, and several side effects from high blood pressure medication, which included headache, dizziness, tiredness and difficulty with concentration.

- Finally, even if I were satisfied that the SEB of Cardiology Technologist was suitable for this worker, I am not satisfied that the LMR Plan had provided her with the appropriate skills with which to obtain employment. As noted in Memo #65, the Board Adjudicator decided to terminate the worker's LOE benefits on May 5, 2004, being of the view that she had enough skills to obtain employment in the SEB. The Adjudicator made that decision despite the fact the worker had not received her final work placement and despite the fact the worker did not have a certification in this field. The worker had raised this issue much earlier. In the Progress Report dated November 18, 2003, the service provider indicated:

> [The worker] also indicated that she was concerned over the fact that she has not yet obtained employment. She reports that she has sent out between 50-100 resumes and to-date she has not had any employment opportunities. She advised that she has been finding that most employers are asking for prospective employees to be certified. [The worker] indicated that the difficulty with getting certified lies in the fact that you are required to have 600 hours of work experience prior to certification. [The worker] is confused as to how to get these working hours when no employer will hire her. In addition to the hours of practical work experience, [the worker] advised that there is a $500 fee to be paid before writing the certification examinations. (…)

- While it may well be that certification is not a requirement for Cardiology Technologists in Ontario, I am satisfied that the Board's failure to assist the worker with this certification and pay the fee for an examination, significantly affected her ability to successfully find employment in the selected SEB. The lack of certification would have been even more significant given the limitations imposed by the worker's compensable shoulder condition.

[34] In summary, after considering all the information before me, I am satisfied that the SEB of Cardiology Technologist was not suitable given the restrictions imposed by the worker's compensable right shoulder condition. As such, the Board should not have terminated LOE benefits on May 5, 2004. The issue of the duration and quantum of benefits flowing from this conclusion is returned to the Board for further adjudication.

DISPOSITION

[35] The worker's appeal is allowed in part as follows:

1. The worker is not entitled to benefits for a psychotraumatic disability.
2. The worker is not entitled to benefits for CPD.
3. The SEB of Cardiology Technologist was unsuitable. The worker is entitled to ongoing LOE benefits beyond May 5, 2004. The issue of the duration and quantum of those benefits will be returned to the Board for further adjudication.

DATED: March 2, 2012

SIGNED: R. Nairn