

CLAIM HISTORY AND APPEAL PROCEEDINGS:

The Worker* seeks to have her benefits reinstated by the Board. She injured her shoulder and wrist while in the course of employment on June 5, 2003. At the time, she was a crab plant worker. She has not returned to her employment.

The Worker's injuries were treated conservatively at first with physiotherapy, medication and acupuncture. The Worker developed chronic pain as a result of her injury and was referred to The Atlantic Spine Clinic in Moncton to attend a multi-disciplinary treatment program. She discontinued participation in the treatment program part way through the program.

A Board Case Manager determined that the Worker had not met her obligations to participate in her recovery and had not taken all reasonable action to mitigate her earnings loss as required by s.84 of the *Workers' Compensation Act*, S.N.S. 1994-95, c.10, as amended [the "Act"]. She therefore suspended the Worker's entitlement to all benefits and services as of May 23, 2005. [June 6, 2005 Decision].

The decision under appeal, dated September 29, 2005, was rendered by a Board Hearing Officer. The Hearing Officer found that the Worker's benefits were appropriately suspended pursuant to s.84 of the *Act*, and she was therefore not entitled to additional temporary earnings -replacement benefits or medical aid assistance beyond May 23, 2005.

The Worker disagrees with the Hearing Officer's findings and appeals to this Tribunal.

I conducted an oral hearing in French in this matter as the Worker is unilingual and French speaking. The Worker testified under oath at the hearing and her representative provided oral submissions. The Worker's representative also provided written submissions dated May 15, 2006. Attached to the submissions was a medical report dated April 6, 2006 from the Worker's family physician, Dr. LaFrance, as well as a previous report from a specialist in Quebec dated February 16, 2000.

The Employer's representative provided written submissions dated April 13, 2006. The Board did not participate on the appeal. Neither the Employer nor the Board were represented at the hearing. I have considered, among other things, the decision under appeal, the contents of the Worker's Board file, the written submissions filed, the submissions and testimony presented at the hearing as well as the additional documentary evidence. However, only portions of the relevant evidence and submissions will be discussed below.

*This decision contains personal information and may be published. For this reason, I have not referred to the participants by name.

ISSUES AND OUTCOMES:

Preliminary Issue:

Did the Board violate the Worker's right to security of the person contrary to s.7 of the *Charter of Rights and Freedoms* (the "Charter")?

No, the Board did not violate the Worker's right to security of the person by refusing to refer her to a French speaking specialist.

Issue on appeal:

Were the Worker's benefits appropriately suspended under s.84 of the *Act*?

The Worker's failure to fully participate in the multi-disciplinary treatment program that included work conditioning and pain related counselling was unreasonable, therefore it was appropriate to suspend her benefits under s.84(2) of the *Act*.

ANALYSIS:

Preliminary Issue:

The Worker's representative argues that the Board did not treat the Worker fairly by failing to accommodate her reasonable requests to be referred to a French speaking specialist, thereby violating her right to security of the person contrary to s.7 of the *Charter*. Specifically, the Worker's representative submits that by failing to accord the Worker the right to meet privately with a doctor with whom she could communicate and who could communicate with her, the Board demonstrated a lack of sensitivity to her needs and breached her *Charter* right to privacy and security. The Worker's representative concludes that on this ground alone the Worker's failure to return to the clinic was justifiable. I disagree.

The Worker was referred to The Atlantic Spine Clinic in Moncton due to the availability of bilingual services at the Clinic. While it is true that the initial assessment interview was with Dr. Evans, who used the services of a translator, the Clinic's treating personnel such as the psychologists are bilingual. The Worker's therapist with whom she worked on a daily basis was Francophone.

The translator present for the assessment by Dr. Evans was someone the Worker referred to as "Jean Guy", the owner of the Clinic. The Worker referred to Jean Guy several times during her testimony. It was not apparent from her testimony that she felt uncomfortable in speaking with Jean Guy or having a "stranger", that is, Jean Guy, present during her

interview and assessment with Dr. Evans. In fact, it was to him that she made the request to see Dr. Evans as her treatments progressed.

The Worker's actions and testimony do not bear out the fact that she resented meeting with Dr. Evans at the outset of her treatment nor resented speaking with Jean Guy or having Jean Guy present for the assessment. In her testimony, the Worker appeared to question the quality of Jean Guy's translation, but not his presence during her assessment by Dr. Evans.

I note that the invoices for the Worker's treatment were sent to the Board by Jean Guy LeClerc on behalf of the Clinic. Assuming that this is the same Jean Guy, he cannot be considered as a stranger.

The Worker's inability to handle the pain associated with her treatment and the difficulties caused by the travel associated with attending the Clinic were the primary reasons given by the Worker for discontinuing her participation in the program. The reasons for her not returning will be addressed when addressing the issue under appeal.

It is also evident from Dr. Evans' initial assessment that he reviewed in detail the Worker's records from Quebec, thus, the fact that the Worker's previous medical records were in French did not compromise her treatment under the direction of Dr. Evans. The fact that he could not communicate with her in French did not compromise the Worker's treatment.

Dr. Evans described the Worker's previous history in a report dated March 15, 2005 as follows:

“As you know, this is a 51-year old lady, with a very lengthy history of right-sided neck, right supraclavicular fossa, and right arm pain. Indeed, this lady's history dates back to at least 1996, when she was employed in Quebec. She did bring a very thick file from Quebec, entirely in French, documenting her troubles with right elbow pain and subsequent evolution through the WCB system in Quebec. I have reviewed the salient features of that file. Essentially, this lady developed right elbow pain, which came to medical attention sometime in 1996. This lady was thoroughly investigated by multiple specialities and ultimately came to surgery with right epicondylar stripping and an interarticular exploration at the right elbow. There were objective findings at that time with the Surgeon documenting synovitis and degenerative change near the head of the radius, at the right elbow. I note from the Family Doctor's contribution to the file that this lady had adaptation difficulties to ongoing pain and seems to have what the Family Doctor felt were long-standing difficulties with anxiety and mood disorder. When I questioned [the Worker] in that regard directly today, she denied any pre-existing difficulties with mood. She attributed all of her problems of mood to

the onset of pain in 1996. I think she did give a history of pre-existing problems with anxiety, though she was very vague in this regard.

The upshot of this complicated pain and psychobehavioural presentation was that this lady was out of the workforce for a protracted period of time, from 1996 until 2001.”

“[The Worker] has had, as noted above, epicondylar stripping on the right side in the past. This was not particularly efficacious, according to the notes. This lady had ongoing right elbow and shoulder pain after that procedure. So much so that the attending Surgeon wondered whether or not she had *casalgia*, now known as Complex Regional Pain Syndrome. He did proceed to a three-phase bone scan in that regard. This investigation was negative save for uptake over the shoulder and epicondyle compatible with non-specific low-grade inflammation. Beyond that investigation, no further consideration was given to a diagnosis of Complex Regional Pain. I note, however, that when Physicians, particularly Surgeons, query this diagnosis it is often in situations of intractable, rather unusual pain. That certainly seems to be the case here.”

The report evidences the consideration Dr. Evans gave to the Worker's past history. The March 15, 2005 report also details the communication between Dr. Evans and the Worker during the assessment. No problems in regards to the translation are evident and Dr. Evans' reporting accords with all the evidence on the file and with the Worker's testimony.

In conclusion, I do not find that the Board has breached the Worker's *Charter* right to privacy and security by failing to accord the Worker the right to meet privately with a doctor with whom she could communicate and who could communicate with her in her own language. There is no evidence of miscommunication due to language difficulties or the use of a translator. The Worker's failure to return to the clinic was not justifiable on that basis.

Issue on appeal:

The Worker is entitled to the benefit of the doubt on any issue involving compensation (s.187 of the *Act*). Where there is a doubt on an issue and the disputed possibilities are evenly balanced, the issue should be resolved in the Worker's favour.

Section 84(1) of the *Act* requires, among other things, that every worker shall take all reasonable steps to reduce or eliminate any permanent impairment and loss of earnings resulting from an injury. A worker must also seek out and co-operate in medical aid or treatment to promote his or her recovery. If the worker fails to do these things, the Board

may suspend, reduce or terminate any compensation otherwise payable to the worker pursuant to s.84(2) of the *Act*.

The obligations in s.84 are worded in terms of reasonable steps which means that a worker's particular circumstances would factor into the decision as to whether the section was breached or not. There is no dispute that the Worker failed to complete an inter-disciplinary pain management program designed to meet her needs. She was referred to a clinic in Moncton because of the availability of bilingual services. Although the pain specialist, Dr. Evans, was not proficient in French, the treating therapist and the psychologists at the Clinic are bilingual.

The Worker's representative argues that the rehabilitation program as presented by the Clinic failed to meet the significant psychological needs of the Worker and therefore she should not be penalized for her failure to complete the program. The Worker also argues that the Board did not make every effort to accommodate her requests to be referred back to Dr. Bachand, a French speaking orthopaedic surgeon who had treated her surgically in Quebec for her elbow. Lastly the Worker's representative argues that, although, the Board gave the Worker additional time to consider returning to the clinic, it did not provide the psychological support to help the Worker make a rational decision.

Language as a Barrier

Notwithstanding my finding in regards to the preliminary issue involving a breach of the *Charter*, there is no doubt that at the outset of the management of the Worker's claim, language was a barrier to effective communication with the Board.

The Worker's temporary earnings-replacement benefits and medical aid assistance were originally terminated as of September 22, 2003, on the basis that the Worker's shoulder tendinitis should have resolved by that time. In a decision dated December 17, 2003, a Board Hearing Officer allowed the Worker's appeal and directed that the Board resume the Worker's benefits as of September 22, 2003. The Hearing Officer ordered that the Board arrange an expedited referral to an orthopaedic specialist. He also noted the Worker's inability to speak English and, therefore, directed that all further correspondence from the Board be translated. Subsequent to this decision, a bilingual Case Manager was eventually assigned to the Worker's case and communication improved.

The Worker was treated by Francophone family physicians where she now resides in Nova Scotia. The Worker's file evidences the ongoing consultation and communication between the Board and the Worker's family physicians. The Board relied on these family physicians to help the Worker understand the results of the medical investigations and to explain the proposed treatments. The services of translators were available to her when she attended medical appointments except for one appointment with Dr. Collicutt. The translators were generally known to her, on one occasion her common law partner served as translator and

accompanied her to Halifax for her MRI.

She was referred to a Francophone specialist in Nova Scotia, Dr. K. Orell; however, Dr. Orell does not handle workers' compensation matters and was unable to treat her.

The results of all of the investigations revealed no objective findings to explain the extent of the Worker's disability, nor the extent of her pain. X-rays, the MRI and EMGs were negative, but for a small tear shown on the MRI.

Notwithstanding the Board's efforts however, the Worker on several occasions requested that she be referred back to Dr. Bachand, a specialist in Quebec. She continues to believe that had she been referred to the specialist, two things might have happened. First of all, the specialist would have directed appropriate treatment and not the type of treatment she received at the Moncton Clinic. She believed that the specialist would not have made her work with weights as was done at the Clinic. She also perceives that the specialist might have a surgical solution to her problem.

The evidence on file does not support her beliefs in this regard. Dr. Leckey, neurologist, in a report dated April 13, 2004, ruled out carpal tunnel and cervical radiculopathy. He suggested that there was no role for neurological intervention. Aggressive physiotherapy and mobilization as well as anti-inflammatories would be the treatment of choice. Dr. Collicutt, an orthopaedic surgeon, in a report dated August 8, 2004 ruled out surgery after an essentially normal MRI scan. He recommended that the Worker be treated conservatively.

There is no medical evidence suggesting that the multi-disciplinary pain management program was inappropriate treatment for the Worker. The Worker's family physician also agreed with the suggested treatment plan. The Worker agreed with the plan. The treatment program included a work conditioning component and pain related counselling.

The Worker filed a February 16, 2000 report from Dr. Hudon suggesting limits to the Worker's functional capacity, that is, to avoid lifting more than 5 kilos with her right arm. This report is dated five years prior to the Worker's treatments at the clinic. Furthermore, subsequent to this time, the Worker was employed as a labourer in a crab plant described as medium labour intensive work. The evidence does not suggest that the conditioning program at the Clinic was inappropriate or harmful.

I note that the Worker's family physician suggested the Worker be referred to Dr. Bachand [August 15, 2004] as language barrier had been of great difficulty.

I conclude from a review of the evidence as a whole, however, that there was no justification to refer the Worker to another orthopaedic surgeon, even if Dr. Bachand was French speaking and had previously treated the Worker. The treatments offered to the

Worker at the Atlantic Spine Clinic not only met the Worker's requirements as a pain management program, but also met the Worker's language requirements in the circumstances.

Language, although a possible barrier to communication, has been perceived by the Worker as a barrier to appropriate treatment. This is not the case. I find that the treatments offered by the Board to the Worker were appropriate to the Worker's condition and that treatments at the Clinic accommodated her language needs.

Breach of duty under s.84

I find also that the evidence in regards to the Worker's psychological needs is insufficient to justify her actions.

Dr. Evans, in his March 15, 2005 report, canvassed in detail the Worker's pain related psychobehavioural screening evaluation. He found as follows:

"[The Worker] is operating under a number of miscognitions with respect to what is certainly a benign pain state. She perceives that it is adaptive for her to continue to interrupt usual activities in the face of ongoing pain. She perceives that she is quite vulnerable to future injury on the basis of ongoing pain or an increase in pain. There is marked cognitive pessimism with respect to returning to work in the coming six weeks or six months. This despite [the Worker's] claim that she would very much like to return to work."

"Having said that, this lady's perception of pain is undoubtedly real to her. At present, we have strong evidence that that perception is associated with multiple maladaptive coping cognitions and a very high perceived level of impairment/disability. As such, unidimensional therapy is not going to be efficacious and I think that explains the failure of trigger point injection and Physiotherapy to-date.

This is a complex psychophysical presentation that is not going to be cured through pain management. The goal of therapy in situations such as this is to optimize home and occupational functionality. We spent quite some time with [the Worker] on precisely those concepts today. This lady is a candidate for interdisciplinary pain management, targeting function, as opposed to pain eradication. I was very clear with [the Worker] in that regard. As such, a program of objectively calibrated and Kinesiology supervised functional restoration exercise would be indicated here to bring this lady to objectively normal levels of functionality, despite residual pain. Concurrent with that

initiative, I think it is essential that this lady be involved with a Pain Specialized Psychologist. We would not be able to offer her the chronic pain relevant Cognitive Behavioural Group Program due to her unilingual status. However, all three of Pain Specialized Psychologists are fluently bilingual and given the complexity of this lady's presentation and suggestion of past somatoform difficulties, I would suggest that, concurrent with the exercise program, we have one of our Psychologists evaluate [the Worker] formally and then proceed therapeutically as indicated."

These extensive quotes from Dr. Evans' report indicate that Dr. Evans identified a strong need for reassurance and psychological support for this program to be successful. Unfortunately, the initial phase of the program seemed to emphasize improving the Worker's level of functioning. It appears that it was successful in that the Worker was able to meet the requirements of a full 8 hour day of light duties. The Worker's testimony, however, has the effect that although she was making a good effort during the treatment, she was increasingly suffering more pain. She states that she requested to see Dr. Evans several times but was refused. She wanted medication.

She attended the Clinic until April 8, 2005. She returned on the Sunday evening to commence her fourth week of treatment and was due to see Dr. Evans on April 12th. She called the Clinic on Monday morning and advised that she was not feeling well (as reported by her treating kinesiologist). On April 12, 2005 the day she was due to see Dr. Evans, she left the hotel without calling the Clinic. When the Clinic tried to reach her at her hotel, staff there indicated that the Worker had left commenting that she was in too much pain and was going home.

Dr. Evans' April 12, 2005 report to the Board describes the treatments offered to the Worker. She commenced treatment effective March 22, 2005. Initial base line testing revealed, in keeping with a largely psychobehavioural presentation, that the Worker was not dramatically deconditioned from a musculo-skeletal point of view. The Worker made objective progress very quickly. By the end of her third week of treatment, she was solidly within the normative range for major muscle group functionality body wide, despite residual pain. The functional capability scan on admission revealed that, contrary to the Worker's perception of near complete or complete disability, the Worker actually possessed full 8 hour sedentary and light residual physical capacity.

Dr. Evans points out that he was to see the Worker at which point he was going to encourage her with respect to her objective progress. She was also to be advised of her appointments with the psychology staff.

Dr. Evans concludes that although the Worker's departure was unfortunate, it was not surprising. He added that the Worker was making excellent progress. He stated that it was not at all unusual for there to be acute onchronic exacerbations, either spontaneously

or in relation to increased activity levels, through the functional restoration exercise program. He added that the Worker's concern would have been addressed in this meeting with her and in all probability, he would have started the nonopioid analgesic trials planned on initial assessment.

He concluded his report by stating that there was a very high level of perceived impairment/disability and that perception runs completely counter to the objective findings which point to normative major muscle group functionality, essentially normal neck and shoulder girdle range of motion functionality, and whole eight-hour light residual physical capacity. Dr. Evans indicates that he would be available to continue treating her in the near future if possible.

Dr. Evans, however, noted in his report that *"I am not impressed that there is or was, on initial assessment, sufficient affective distress or psychiatric illness to impair this lady's decision making process"*.

The Worker's representative has not referred to medical evidence that would suggest that the Worker was unable to make rational choices at the time she left the Clinic nor after when the Board gave her the opportunity to return to the Clinic.

Following her departure from the program, the Worker was contacted by the Board. She indicated that she was in too much pain and that she found the travelling to and from her residence to the Clinic in Moncton very difficult. She elaborated on this issue during her testimony. There is no doubt that a five hour drive every weekend on Friday afternoon to return home and then on Sunday evening to return to Moncton was fatiguing. It was difficult for the Worker to stay alone in a hotel room in Moncton during the week. However, these difficulties are not unusually challenging considering the potential benefits of the treatment program.

I have considered the reasonableness of the Worker's actions in the context of her treatment program. She demonstrated willingness to participate in the program. She was compliant with all requirements of the program. She made excellent progress. Functionally she was capable of an 8 hour sedentary day. Although she had residual pain, the Worker was aware that the program would not eliminate her pain but would help her function with her pain. She understood the modalities of the program.

The Worker testified that she requested to see Dr. Evans prior to her scheduled appointment to address her need for pain medication, yet she chose to leave on the morning she was to see Dr. Evans.

As Dr. Evans suggested in his report, the exacerbation of pain experienced by the Worker was not unusual and it perhaps was understandable that she did not want to go back and continue her treatments, it is unreasonable for her to have left the program without meeting

with Dr. Evans at her scheduled appointment. The fact that Dr. Evans used a translator does not appear to have bothered the Worker at that time. She seemed to be comfortable to converse and to work with the therapists and the owner of the Clinic. Why she did not stay to see Dr. Evans and to discuss her need for medication and psychological counselling can only be viewed as a choice the Worker made because of her perception that her condition was worsening. She was, and is, still convinced that the physical treatments made her worse and were not appropriate, believing again that if she was referred to her previous specialist, other forms of treatment would be recommended. The perception is not based on reality.

The Board afforded the Worker an opportunity to return to the Clinic. The Worker's Case Manager discussed the issue with the Worker. The Worker's family physician was fully appraised of the situation.

The Worker says that she wants her arm back. She does not want to live with the disability she currently has and the inability to enjoy the activities that she previously enjoyed. She says that she would go to see a French orthopaedic specialist or a French psychologist. The evidence does not suggest that a referral to an orthopaedic specialist, French or otherwise is warranted. Referral to a psychologist is certainly warranted. Bilingual psychologists are available at The Atlantic Spine Clinic. Treatment within the Clinic that specializes in treating patients with chronic neck and back pain is the preferred location for such treatment.

Should the Board send her to a French orthopaedic specialist in order to be reassured that the course of treatment is appropriate? The evidence suggests that this will not satisfy the Worker.

Should the Worker have been offered psychological counselling earlier in the treatment either at the Clinic or otherwise? The evidence suggests that her treatment was appropriate. She was progressing well. If she felt an exacerbation of pain, she would have had the full opportunity to discuss this with Dr. Evans. However, she chose to leave the Clinic on the morning she was to meet with him. Her departure was unreasonable in the circumstances.

In summary, the treatment program offered to the Worker at the Atlantic Spine Clinic was appropriate for the Worker's condition and offered appropriate bilingual services. There is insufficient evidence to suggest that the Worker was not able to make rational choices when she left and failed to return to the Clinic.

The Worker left the Clinic because of increasing pain and fatigue cause by the travel every week to the Clinic. The Worker has real pain but perceives her disability to be far greater than it is in reality due to her pain. The Worker has communication difficulties because she is unilingual, however, her perception that she is not being understood and not getting

appropriate treatment as a result is not based on reality either.

Considering all of the evidence, I find that the Worker's failure to participate in the treatment program at the Atlantic Spine Clinic was unreasonable. The Worker has breached her obligations under s. 84 of the *Act* to cooperate in treatment to promote her recovery. The Board was justified in suspending her benefits.

I note that the Board has "suspended" the Worker's benefits. I also find that, in view of Dr. Evans' report and the progress reports from the Clinic, the Worker would benefit from the Clinic program should it be offered again to her. It is an appropriate bilingual program.

I direct the Board to investigate the possibility of the Worker's return to the program even after a one-year delay should the Worker indicate her willingness to participate in the program.

CONCLUSION:

The appeal is denied. The Worker's benefits were appropriately suspended by the Board under s.84 of the *Act*.