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East End Multidisciplinary Pain Management Program

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This report is an example of a patient with no significant pre-accident medical history who was involved in a motor vehicle accident.

INDEPENDENT PSYCHIATRIC ASSESSMENT

Patient:	**Mr. XXXXX**
Date of Birth:	**Date**
Date of Report:	**Date**
Date of Loss:	**Date**
Evaluator:	**Dr. J.H. Ennis, Psychiatrist**

QUALIFICATIONS:

I am a duly qualified medical practitioner licensed to practice by the College of Physicians and Surgeons of Ontario. I obtained my MSW degree at the University of Toronto in 1982, and my MD degree at McMaster University in 1988. Following my residency in psychiatry, I participated in an additional three years of supervised training in the treatment of patients with chronic non-cancer pain. I am a Consultant in Psychiatry and certified as a Fellow of the Royal College of Physicians and Surgeons of Canada in this specialty. I was an examiner for the College of Physicians and Surgeons of Ontario. I held the position Associate Director of the Chronic Pain Management Unit at Chedoke Rehabilitation Services. Currently, I am Director of the *HSO Pain Management Group* and Director of the *East End Multidisciplinary Pain Management Program*, located within *St. Joseph's Healthcare: Centre for Ambulatory Health Services* , Hamilton, Ontario. I hold cross appointments in the Department of Physical Medicine and Rehabilitation, and the Department of Psychiatry and Neurobehavioural Sciences. I am a part-time clinical Assistant Professor in the Faculty of Health Sciences at McMaster University in Hamilton, Ontario, Canada. My clinical practice is devoted to the treatment of patients with chronic non-cancer pain.

Patient:	**Mr. XXXXX**
Date of Report:	**Date**
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	Date
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CONSENT*:*

At the outset of the assessment I did have Mr. XXXXX complete a form 14 consent to disclosure of information. I also spent time with the patient reviewing the role of the expert witness. I had him sign a document which describes the role of the expert witness. Finally, Mr. XXXXX did sign a document which clearly outlines the limits of confidentiality in the context of this assessment

Mr. XXXXX was seen for an independent psychiatric evaluation at the request of his legal representative. If a physical examination is carried out it is carried out in the presence of my secretary, Ms. GGGGG. The nature of the examination was explained. Mr. XXXXX understood that he could stop the examination at any point for any reason. If pain was produced by any test or other aspect of the examination it should be brought to my attention and the test would be discontinued. The patient understood that he could make such a request without jeopardizing his situation and had no objection to the copy of this letter being forwarded to the following:

Mr. ZZZZZ

Mr. XXXXX understood that I have been asked by his legal representative to provide an unbiased response to the following questions/issues:

1. **What are the results of my examination of the Mr. XXXXX?**

2. **What is my opinion in regards to diagnosis?**

3. **What, if any, effect have the injuries suffered in this motor vehicle accident had on Mr. XXXXX's ability to function in the workplace and household?**

4. **What, if any, contribution did the motor vehicle accident make toward Mr. XXXXX's present condition?**

5. **What is my opinion in regards to prognosis?**

6. **Are there any treatment recommendations?**

In addition, I reviewed with Mr. XXXXX the legal requirements of an expert. Mr. XXXXX signed a document indicating that he understood the role as outlined below.

Mr. XXXXX stated that he understood the purpose of the assessment and gave his consent for it to proceed.

4.1.01 (1) It is the duty of every expert engaged by or on behalf of a party to provide

evidence in relation to a proceeding under these rules,

a) to provide opinion evidence that is fair, objective and non-partisan;
b) to provide opinion evidence that is related only to matters that are within the expert's area of expertise; and
c) to provide such additional assistance as the court may reasonably require to determine a matter in issue.

(2) The duty in subrule (1) prevails over any obligation owed by the expert to the party by whom or on whose behalf he or she is engaged.

Mr. XXXXX stated that he understood the purpose of the assessment and gave his consent for it to proceed.

SOURCE OF DATA:

Reports:

- Acupuncture Notes
- Records of Dr. LLLLL from 'date' to 'date'
- X-ray of the Colon with Double Contrast dated 'date'
- MRI of the Cervical Spine dated 'date'
- X-ray of the Cervical Spine dated 'date'
- Report by Physiotherapy completed by L. ZZZZZ (physiotherapist) dated 'date'
- Report by Physiotherapy completed by L. ZZZZZ (physiotherapist) dated 'date'
- Letter from Dr. XXXXX(primary care physician) dated 'date'
- Report by K. ***LLLLL*** (chiropractor) dated 'date'
- Report by R. ***LLLLL*** Acupuncture Clinic dated 'date'
- Report by Physiotherapy completed by L. LLLLL (physiotherapist) dated 'date'Report by ***LLLLL*** (neurologist) dated 'date'
- Occupational Therapy In Home Functional Assessment completed by ***LLLLL*** (OT) dated 'date'
- Report by ***LLLLL*** (chiropractor) 'date'
- Consultation Report by ***LLLLL***(neurologist) dated 'date'
- Report by ***LLLLL*** dated 'date'
- Report by Physiotherapy completed by ***LLLLL*** (physiotherapist) dated 'date'Report by ***LLLLL*** dated 'date'
- Consultation Report by ***LLLLL*** (physiatrist) dated 'date'
- Discharge Report by Physiotherapy completed by ***LLLLL*** (physiotherapist) dated 'date'
- Orthopedic Assessment by ***LLLLL***(orthopaedic surgeon) dated 'date'Ambulance Call Report dated 'date'Emergency Room Cover Sheet dated 'date'
- Plain Film X-ray of the Cervical Spine dated 'date'
- X-ray of the Lumbar Spine dated 'date'Consultation Report by ***LLLLL*** (physiatrist) dated 'date'

- X-ray of the Right Knee dated 'date'X-ray of the Right Knee dated May 15, 2009
- Report by ***LLLLL*** (physiotherapist) dated 'date'
- Job Assessment, Insurer's Examination dated 'date' completed by ***LLLLL*** (OT)
- Orthopedic Assessment by ***LLLLL*** (orthopedic surgeon) dated 'date'
- MRI of the Spine dated 'date'Occupational Therapy Functional Assessment completed by ***LLLLL*** (OT) dated December 'date'
- Report by ***LLLLL*** (primary care physician) undated
- Report from After Hours Clinic dated 'date'
- X-ray of the Thoracic Spine and Lumbar Spine dated 'date'
- Functional Abilities Evaluation completed by ***LLLLL*** (kinesiologist), ***LLLLL*** (OT) dated 'date'Report by ***LLLLL*** (physiatrist) dated 'date'
- Independent Medical Evaluation completed by ***LLLLL***(physiatrist) dated 'date'Report by ***LLLLL***(massage therapist) dated 'date'
- Report by ***LLLLL***(physiatrist) dated 'date'
- Report by ***LLLLL*** (physiatrist) dated 'date'
- Psychological Report by ***LLLLL*** (psychologist) dated 'date'
- Report by ***LLLLL*** (psychologist) dated 'date'
- Transferable Skills Analysis completed by ***LLLLL*** (Rehabilitation Consultant) and ***LLLLL*** (Manager Rehabilitation Services) dated 'date':
- Pre-Return to Work Support and Facilitation Report by ***LLLLL*** (OT) dated 'date'
- Orthopedic Assessment by ***LLLLL*** (orthopedic surgeon) dated 'date'
- Report by ***LLLLL*** (OT) dated 'date'
- Addendum Transferable Skills by ***LLLLL*** (rehabilitation consultants) dated 'date'
- Report by ***LLLLL*** (OT) dated 'date'
- Report by P. Miller ***LLLLL*** dated 'date'
- Addendum to Functional Abilities Evaluation completed by ***LLLLL*** (rehabilitation assessors) dated 'date'
- Report by ***LLLLL***(OT) dated 'date'
- Report by ***LLLLL*** (psychologist) dated 'date'

Clinical Assessment:

A clinical assessment was conducted at the Medical Arts Building in Hamilton, Ontario on date.

Note: Mr. XXXXX was accompanied by a translator, Mr. QQQQQ. He was also accompanied by his wife who remained throughout the assessment. Mr. XXXXX's wife is somewhat literate in English but Mr. XXXXX is not able to carry on a conversation in English. All questions and answers were translated through Mr. XXXXX. The language spoken was Mandarin Chinese.

Patient:	**Mr. XXXXX**
Date of Report:	**Date**
Date of Loss:	**Date**
	Date
Evaluator:	**Dr. J.H. Ennis, Psychiatrist**

SECTION I

The information contained within this section derives solely from the subjective verbal history provided by the patient.

IDENTIFYING DATA:

Mr. XXXXX is a 52-year-old man of Vietnamese extraction having come to Canada in 1900. He is married and has a xx year old daughter. Prior to the accident that took place on date (Index MVA). Mr. XXXXX indicated that he had no physical or psychological problems. Associated with the two accidents has been the onset of axial spine pain, right arm, shoulder and hand pain, headaches and left knee pain. His level of function is reduced.

HISTORY:

Accident Dated:

At this time Mr. XXXXX was driving a Chrysler van. He was alone and wearing a seat belt. He proceeded through a green light and was driving in the curb lane. A car beside him started honking its horn and ultimately cut his vehicle off. Both of his front air bags deployed and the other car flipped onto its side. Mr. XXXXX indicated that he was in a "state of unconsciousness". He then recalls people yelling. He opened his eyes. He opened the door of the vehicle and saw liquid on the ground. He thought it was gas and so "ignoring (his) pain, (he) got out of the vehicle". He reported that he had chest pain, both hands felt weak and he had pain in the low back, right shoulder, arm and hand.

An ambulance arrived at the scene of the accident. Mr. XXXXX was examined by the ambulance attendants and told that he had no fractured bones. He was asked if he wanted to go to the hospital. At the same time, his daughter was going to be dropped off at home and if he did not get home, she would be alone. His wife was working at a factory at the time. He was concerned about getting home. In spite of "terrible pain" he decided that he was able to walk and therefore he should go home.

I did point out the contradictory nature of Mr. XXXXX's description of how terrible his pain was and the fact that he did not go to the hospital. He and his wife indicated that he pushed himself, in spite of the pain, to go home because of concern for the daughter.[1]

At some point during the evening Mr. XXXXX spoke with his wife who reported that he was aching all over. She asked why he did not go to the hospital and he stated that he was concerned about his daughter.

Mr. XXXXX's wife is no longer working. She was diagnosed with fibromyalgia in about 2009 and has not worked since that time. Currently she is receiving income support through CPP and long term disability. Since the accident she now has increased stress and therefore more pain. Ms. XXXXX reported that she takes care of her husband more than she takes care of her own child because he has a poor memory.

Following the first accident Mr. XXXXX attended physiotherapy, acupuncture and massage. He reported that it helped a bit but there was constant changes in the timing of the treatment because treatment plans were often delayed or not started. There would be months at a time during which he was not receiving any treatment and then it would start again. He reported seeing a physician in location who suggested he return to work and so he did.

Mr. XXXXX returned to work in early 2008. He worked for several days but could not "fulfil the duties of (his) job". He was able to manage a few hours in a day and then he would have increased neck, hand and low back pain. His supervisor suggested he stay for the full day in the factory and relax before going home. Mr. XXXXX has not returned to work since 2008.

Level of Function:

Prior to the accident Mr. XXXXX worked full-time which he has done since coming to Canada. He often worked overtime hours. He helped out with all aspects of chores within the home. He did lawn care and shovelled snow in the winter. He spent time with his daughter and he and his wife often socialized.

Ms. XXXXX indicated that prior to the accident Mr. XXXXX was identified as being a good worker at the workplace. He got letters of merit and was given gifts in recognition of his efforts. He worked for the company from date until the accident date).

Following the first accident Mr. XXXXX's capacity to do housework reduced. He

[1] Please note: All of the author's (Dr. Ennis) comments in regards to consultation reports will be in italics and 'border filled' in light grey.

continued to do it but he did it more slowly. He continued to shovel snow and cut the grass although his wife reported that after he cut the grass three times he told her that he could not do it anymore. He stated that he used his left hand to guide his lawn mower because his right hand was painful.

Ms. XXXXX reported that he did some dishwashing and he used a small vacuum cleaner. Their house has hardwood floors only. He used his left hand to do the work.

Accident Dated:

Almost one year after the first accident Mr. XXXXX was involved in a second accident. He had just come to a stop at a pedestrian cross walk when he was hit from behind while driving a car. He reported that he had increased pain all over and therefore stayed in his car for a "long long time". The other driver approached his vehicle and asked if everyone was all right. The daughter reported having neck pain which continues to bother her "a bit". The patient and his daughter were taken to the local hospital. When the wife arrived the daughter was wearing a soft collar and the husband had had been given some type of injection. They were both discharged from the hospital.

Current Symptoms:

Mr. XXXXX reports having chronic nose bleeds which he associates with increased pain.

In general, Mr. XXXXX associates all of his health related issues, such as recent problems with his eyes, to the accident.

Mr. XXXXX reports bitemporal head pain radiating to the top of the cranium and then radiating into the right shoulder, down the arm and into the right hand, affecting the three middle fingers of the hand. The headaches can be associated with nausea and he reported vomiting. However he uses a Chinese lotion under his nose which reduces the nausea.

Mr. XXXXX brought the lotion with him. The primary ingredient in the lotion is Salicylate. Salicylate is not used in the treatment of nausea.

Mr. XXXXX reports right shoulder, arm and hand pain. He has pain in the palm of the hands and the middle three fingers. He described the right index finger as becoming numb when it touches cold water or when it is outside in the winter.

At this point I did ask the patient to demonstrate power by squeezing my fingers with his right hand. He provided a sub maximal effort. No pressure was applied to the examining hand.

Mr. XXXXX reports having tinnitus bilaterally. He has chronic low back pain that increases with all activity and he has right knee pain that increases when he goes upstairs, downstairs or walks for long distance.

Level of Function Following the Second Accident:

Since the second accident Mr. XXXXX does even less. He reports doing a bit of vacuuming. He will help with dishes but does less than half of the task. He does some light dusting. He will do exercise in the morning and the afternoon. He lies down off and on throughout the day. He watches television. His wife will force him to come out with her when she goes grocery shopping because she is concerned about him staying home doing nothing. They do visit friends from time to time.

Intimacy is "very bad". As best as I can tell Mr. XXXXX's libido is intact but he is avoidant of intimacy because of pain. The wife reports that intimacy is less frequent.

Mr. XXXXX spends less time with his daughter and he is described as becoming easily upset with her. The daughter is worried about him.

PAST MEDICAL HISTORY:

The patient did not report any significant pre-accident medical history. Now, he is awaiting some type of surgical intervention for his eyes.

PAST PSYCHIATRIC HISTORY:

Non contributory.

MEDICATIONS:

Topramycin/Dexamethasone eye drops

Fentanyl 25 micrograms.

Mr. XXXXX indicated that this medication is helpful except his pain increases dramatically with changes in weather. When this happens he will use a Chinese

ointment. I did review the content of the ointment. It is made up primarily of various herbs.

Tylenol #3 one to four tablets. If the patient has difficulty sleeping at night he will take a Tylenol #3 in the middle of the night.

The patient was advised to stop using Tylenol in this way.. When a patient is being treated with Fentanyl, the use of Tylenol 3 is not in his best interest for the purpose of sleep induction.

Nortriptyline 25 mgs. He reports that when his pain increases the medication does not help.

Sertraline 50 mgs. Mr. XXXXX stressed that he had been told not to increase this medication too quickly. He has been on this dose for two years. His wife reports that it has helped improve his mood.

Evidence indicates that some patients will have a full response at 50mg. However, in my opinion, the patient has not had a therapeutic response to this dose of medication.

Mr. XXXXX is allergic to shrimp but not to any medications. He stopped smoking eleven years ago. He does not abuse substances.

FAMILY MEDICAL AND PSYCHIATRIC HISTORY:

The patient's mother developed hypertension when she was over 80 years of age. The father is deceased.

PERSONAL HISTORY:

Mr. XXXXX was born in location. He has two younger brothers and one younger sister. The brothers still live in Location with the mother and his sister lives in New Jersey. He is in telephone contact with all of them. When he was young he was living in Location during the Location war. He grew up in location. He described his family as being made up of poor workers. He did not have much time in school.

Once the Americans left Location the Vietcong came in. They forced people to go into the fields to work. Mr. XXXXX had to do this at least one month a year. Otherwise he was working as an apprentice. He was training to do electronic repairs. He did complete his apprenticeship but as was typical in Location, no diploma was given. When he came to Canada his skills were not recognized. Mr. XXXXX indicated that he was not the victim of any direct violence under the Vietcong. He denied having

nightmares related to his youth.

Upon examining the available documentation it was reported that during the war the patient was a child and he saw deaths and bombings. He saw bodies lying in the street. Mr. XXXXX appears to have under reported his experiences in Location.

After coming to Canada Mr. XXXXX did try to do some electrical repair work, but because he is not licenced he is unable to buy parts and he had to stop doing this type of work. As noted previously he has worked as an operator since 1993. He and his wife met in 1982. The wife came to Canada is 1991. She sponsored him into Canada in 1993. She came in 1991 and he came in 1993. They married in Canada but had known each other for a long time. The wife is very supportive of the husband.

Ms. XXXXX indicated that she takes more care of her husband than her child. She gave an example that when he goes out driving for long distances she will go with him. After close questioning she goes with him because she feels nervous not because he requires her presence.

MENTAL STATUS EXAMINATION:

Mr. XXXXX presented as a well-groomed pleasant man. He displayed pain behaviours throughout the assessment. He was wearing three braces on the right arm. He wore a brace at the wrist, below the elbow and across the biceps. He was chronically rubbing his right knee and flexing and extending his right leg. He stood up and down throughout the assessment and winced on a regular basis.

Mr. XXXXX indicated that he is irritable and at times he becomes depressed, but when he becomes depressed he then thinks about his wife and daughter and he feels more hopeful. His appetite is reduced and his wife reports that he has had to buy clothes that are two sizes smaller than he used to wear. He is relatively inactive and appears to be anhedonic. Sleep is associated with middle insomnia. He has low energy and poor concentration. When asked about how he feels about himself he stated that everything is not going right and that he feels he cannot do anything. His wife then described him as having previously been “diligent”. She reported that he used to like going to work every day. The patient adamantly denied suicidal ideation or intent. There was no evidence of mania or hypomania.

Mr. XXXXX denied having panic attacks. He is not uncomfortable driving. However he does report having nightmares related to the accident weekly or daily. He is more cautious while driving but he is not avoidant of the area where the accident occurred. He does not endorse true flashbacks. The patient’s thought form and content were normal and there was no evidence of perceptual disturbance.

Cognitive examination was completed using the Montreal Cognitive Assessment Scale which scored 28 which is considered a normal score.

BRIEF PHYSICAL EXAMINATION:

A brief physical examination was conducted. Utilizing standardized fibromyalgia tender points Mr. XXXXX reported pain with less than feather light touch on his left trapezius and supraspinatus. The pressure was so light that there was no dermal movement. The same occurred with palpation of the lumbar spine and the right SI joint. Extremely light pressure on the head was associated with reports of severe neck pain.

On range of motion Mr. XXXXX barely moved his neck in any direction although on observation there is evidence of at least ½ normal range of motion.

Examination of the lumbar spine showed flexion to about 20 degrees with minimal extension, lateral bending or rotation.

Patient: **Mr. XXXXX**
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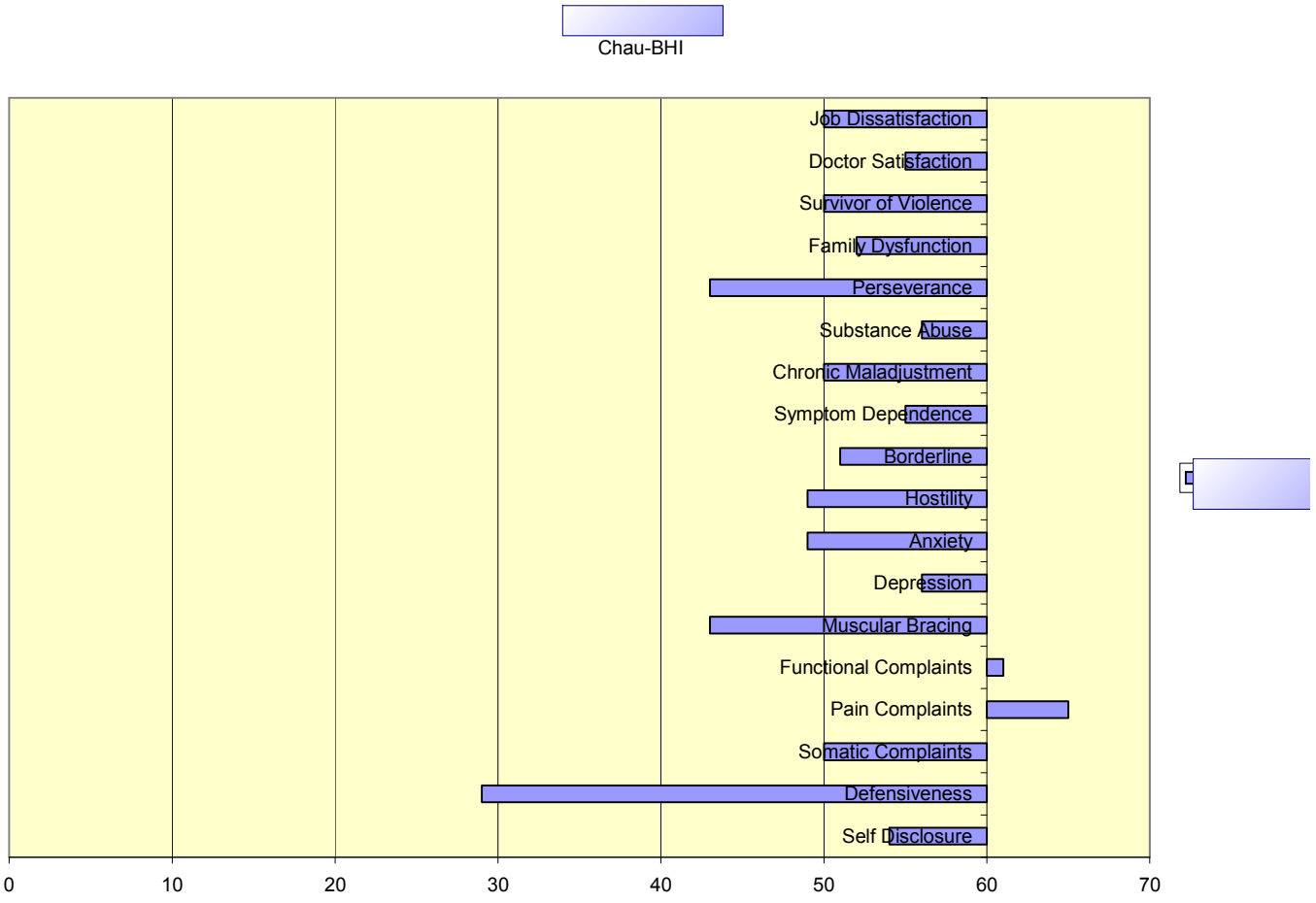
SECTION II

The information in this section derives solely from objective psychometric testing.

On the **BEHAVIOURAL HEALTH INVENTORY II**[2]

General:



[2] Note: All tests are in English. Mr. XXXXX completed them by having the questions translated to him. This could have an impact on the results.

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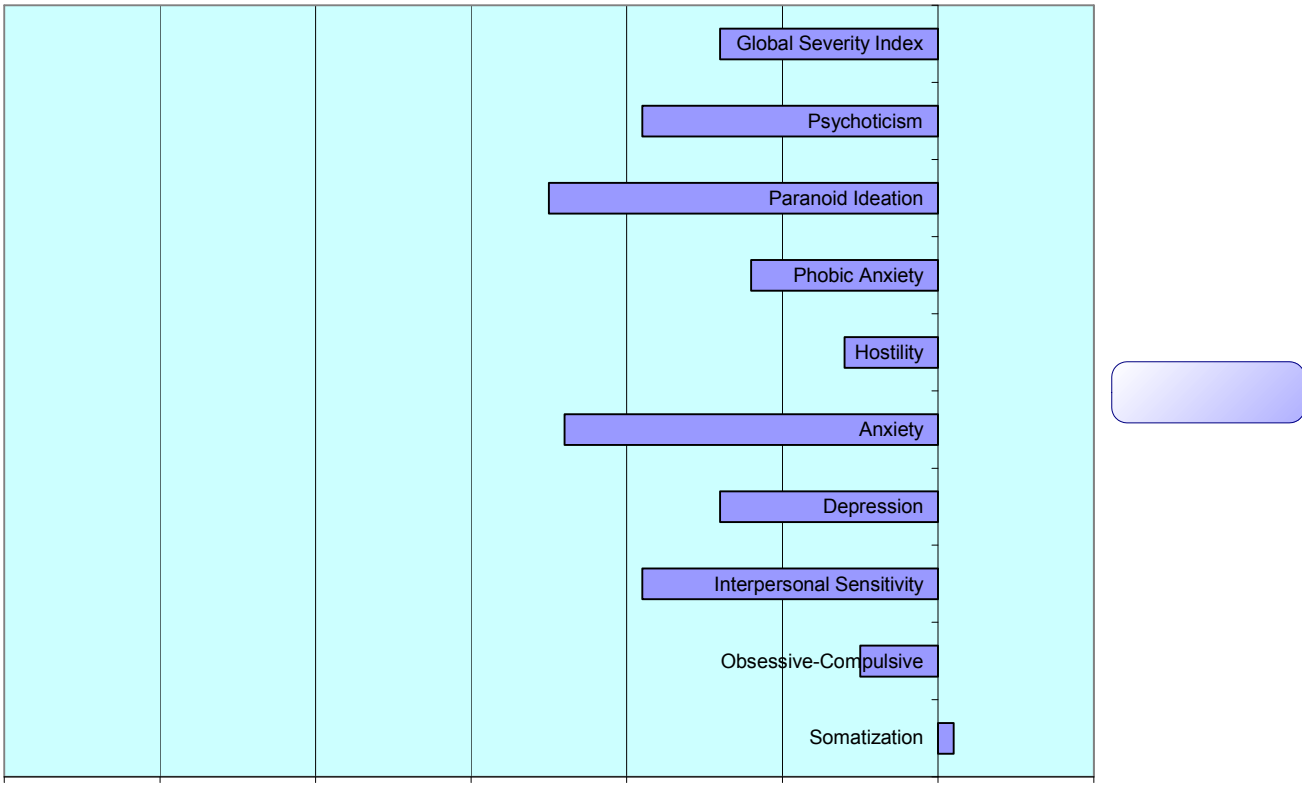
Subscales scores above 60 are considered of clinical significance. The only elevation noted is on Pain Complaints, consistent with the patient's reports of pain.

Psychopathology:



On the **SCL90-R**

On the SCL-90-R, subscales with T-Scores above 60 are considered to be clinically significant. A clinically significant elevation is noted on the somatization subscale.

On the **PTSD CHECKLIST** the patient's total was 42. However, his answers did not meet criteria for Posttraumatic Stress Disorder (PTSD).

On the **ALCOHOL USE DISORDERS IDENTIFICATION TEST (AUDIT)**, the patient scored 2. This is below the cut off of 8-10 indicating no issues related to alcohol use.

On the **DRUG USE DISORDERS QUESTIONNAIRE** Mr. XXXXX indicated that he has never used any substances.

On the **SOAPP** scores above 7 are considered to be an indication of risk of addiction to opioids. Mr. XXXXX scored 2.

On the **PAIN CATASTROPHIZING SCALE** scores above the 75th percentile are considered to be clinically significant. Mr. XXXXX's total score was in the 50th percentile. He scored in the 45th percentile for rumination, in the 60th percentile for the helplessness subscale and the 42nd percentile for magnification.

Patient: **Mr. XXXXX**
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On the **DETAILED ASSESSMENT OF POSTTRAUMATIC STRESS (DAPS)**

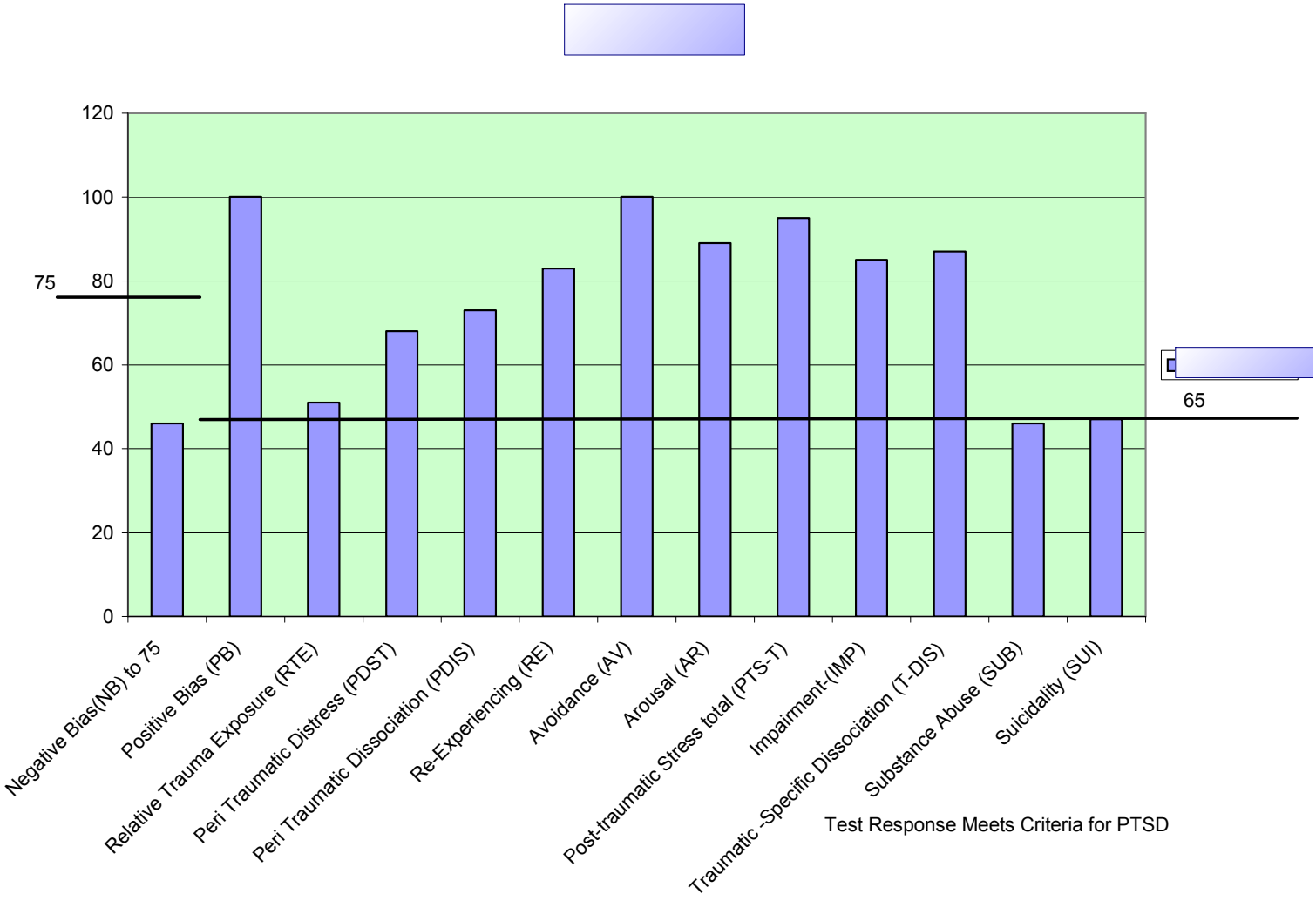

Table 1
Description of the Detailed Assessment of Posttraumatic Stress (DAPS) Scales

Domain/Scale	Description
Validity Scales	
Positive Bias (*PB*)	Evaluates the extent to which respondents deny low-level psychological symptoms or problems that most people would endorse to some degree. Individuals with high scores are likely to be especially defensive or avoidant, invested in presenting themselves as psychologically symptom-free, or otherwise unwilling to endorse commonly endorsed items.
Negative BIAS (*NB*)	Assesses willingness to endorse statistically unusual phenomena (e.g., going blind for several minutes at a time) or seemingly unlikely experiences (e.g., being able to read minds) that most individuals in the standardization sample rarely described. High scores on this scale may reflect an attempt to present onself as especially symptomatic, either as a "cry for help" or as a misrepresentation for secondary gain.
Trauma Specification Scales	
Relative Trauma Exposure (*RTE)*	Represents the sum of the first 12 trauma exposure items of the DAPS trauma specification section. High scores indicate that the respondent has experienced more types of potentially traumatic events in his or her life than most people in the standardization sample. High scores may signal more complex trauma impacts and, by implication, risk of future victimization.
Onset of Exposure (*ONSET*)	Single item that evaluates how recently the index trauma occurred, rated on a scale of 1 (*In the last day*) to 5 (*A year ago or longer*).
Peritraumatic Distress (*PDST*)	Measures the extent of distress the respondent experienced in a variety of areas at the time of the trauma, including fear, horror, helplessness, guilty, and shame. High scores indicate greater immediate traumatization and are often associated with greater overall posttraumatic stress.
Peritraumatic Dissociation (*PDIS*)	Assesses the degree to which the respondent dissociated during the index traumatic event, primarily in terms of depersonalization or derealization. High scores suggest a risk factor for more severe posttraumatic stress as well as a probable marker for general dissociative tendencies.
Posttraumatic Stress Scales	
Reexperiencing (*RE*)	Evaluates the reexperiencing symptom cluster of PTSD and ASD, including intrusive thoughts, flashbacks, memories, and dreams of the traumatic event, as well as psychological distress and autonomic reactivity to trauma-reminiscent events and stimuli. Respondents with high scores are likely to be experiencing significant posttraumatic stress.
Avoidance (*AV*)	Assesses the avoidance responses found in PTSD and ASD, including attempts to avoid people, places, conversations, and situations that might trigger intrusive reexperiencing symptoms; attempts at thought suppression and feeling avoidance; and emotional numbness, foreshortened future, and loss of interest. Because the environment potentially contains many triggers for posttraumatic reexperiencing, some individuals with high scores seclude themselves or otherwise avoid certain social interactions.
Hyperarousal (*AR*)	Taps the autonomic hyperarousal cluster of PTSD and ASD symptoms, such as tension, sleeping difficulties, irritation, problems with attention and concentration, hyperalertness, hypervigilance, and heightened startle responses. Respondents with high scores often complain of emotional distress associated with high anxiety,

	irritability, and constantly being "on edge". Individuals with elevated scores also may have somatic complaints reflecting hyperarousal effects on the body.
Posttraumatic Stress-Total (*PTS-T*)	Represents the sum of *RE, AV,* and *AR,* and thus evaluates the overall severity of PTSD symptoms experienced by the respondent. PTSD severity is categorized as *Mild, Moderate,* or *Severe* based on the *PTS-T T* score.
Posttraumatic Impairment (*IMP*)	Assessed the psychosocial impairment associated with PTSD and ASD, including difficulties at work, school, social situations, or in relationships as a result of posttraumatic stress. Individuals with elevated scores report the effects of trauma exposure as debilitating and as interfering with their capacity to function on a daily basis.

Associated Features Scales

Trauma-Specific Dissociation (*T-DIS*)	Evaluates dissociative responses that are directly linked to the index traumatic event. Taps those derealization, depersonalization, and detachment symptoms that often follow exposure to overwhelming trauma. Respondents with high scores are often distracted, emotionally "shut down", or numb, and, in the time period immediately following the trauma, they may present as somewhat confused or out of touch with their immediate environment.
Substance Abuse *(SUB)*	Measures respondents' self reported recent use of drugs, including heroin, cocaine, stimulants, depressants, and marijuana, as well as signs of chronic alcohol abuse, including excessive drinking, blackouts, and social impairment. Individuals with high scores may have serious alcohol and/or drug problems that may precede or follow their trauma exposure.
Suicidality *(SUI)*	Measures suicidal motives, ideations, and behaviours, including wanting to end one's life; thinking, fantasizing, and making plans for suicide; threatening to kill oneself; engaging in dangerous acts in the hope of death; and reports of previous suicide attempts. Elevated scores should always be followed up with a detailed suicide-risk interview.

Patient: **Mr. XXXXX**
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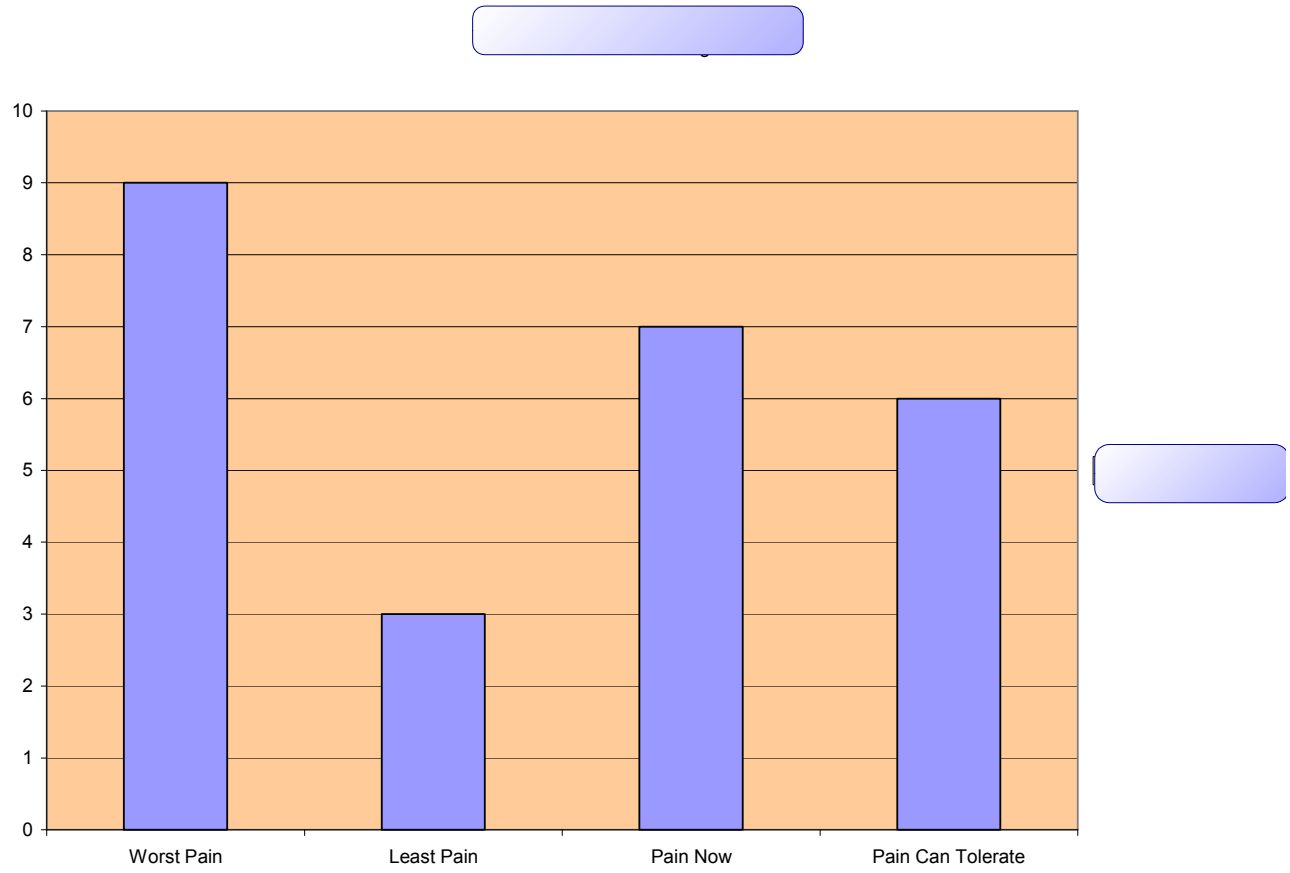
Pain and Disability:

On the **PAIN RATING SCALE:**



The
patient reports that he can tolerate 5/10 pain.

On the **PAIN DISABILITY INDEX** the patient's total score was 48. This score is slightly above scores typically seen in patients with chronic noncancer pain involved in litigation. For the family and home responsibilities subscale he scored 6 out of 10 with 10 being total disability and 0 being no disability. For the recreation subscale he scored 5. Social activity was scored at 7, occupation at 8, sexual activity at 7, self care at 7 and life support activities at 8.

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On the **HAND SORT**, Mr. XXXXX's score puts him below the 5th percentile indicating that he believes his is capable of less than sedentary work as a result of hand related problems.

On the **SPINAL SORT,** Mr. XXXXX scored below the 5th percentile indicating that he perceives himself as being able to manage below sedentary work as a result of spine related issues.

On the **OSWESTRY BACK PAIN AND DISABILITY QUESTIONNAIRE** the patient scored 62 indicating that he perceives himself as crippled as a result of back pain.

On the **OSWESTRY NECK DISABILITY QUESTIONNAIRE** the patient scored 56 indicating that he perceives himself as severely disabled as a result of neck pain.

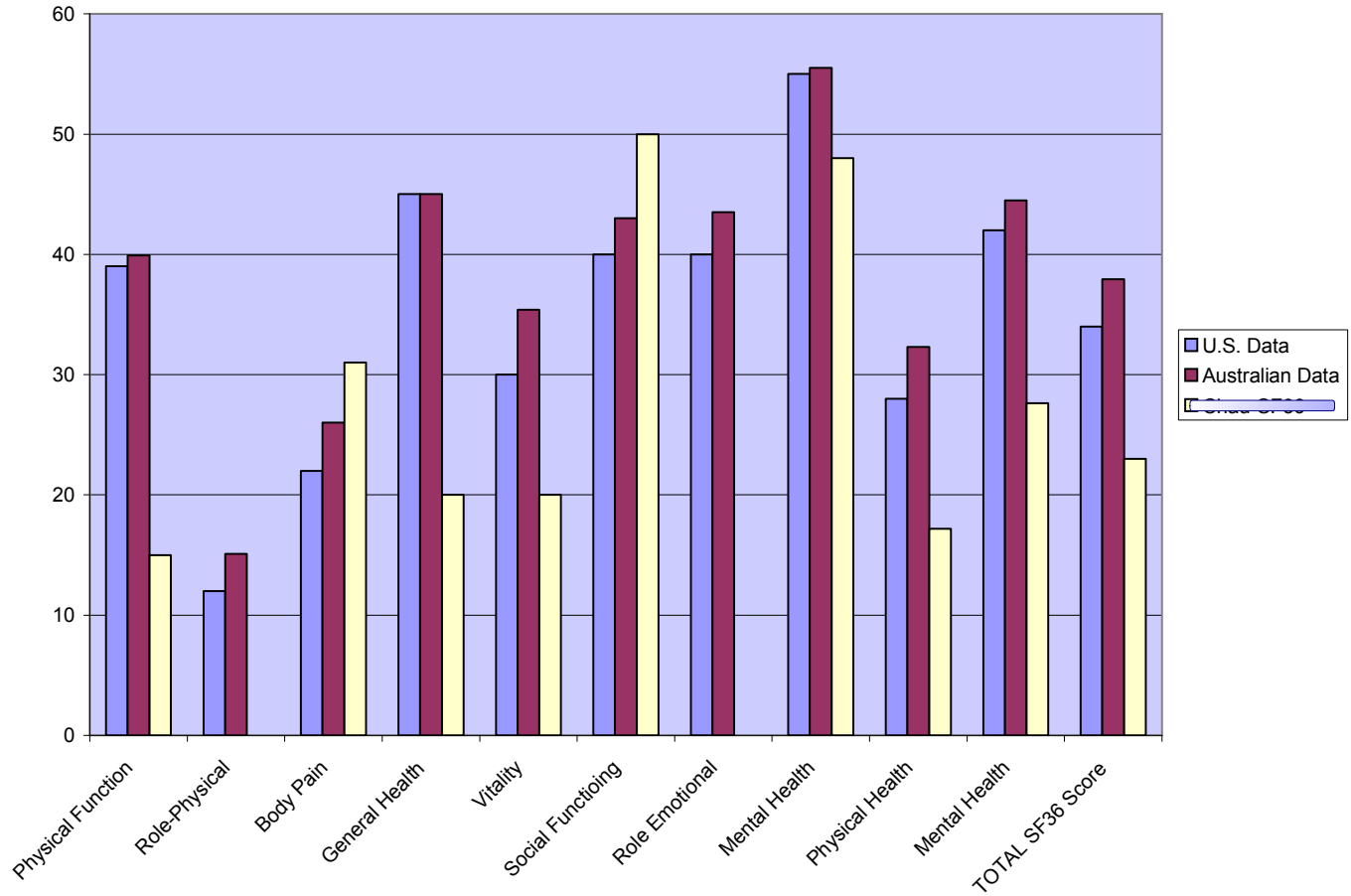
The patient's **KARNOFSKY** score is 70 indicating that he is able to care for himself but is unable to perform normal activity or do active work.

On the **HEADACHE IMPACT TEST** Mr. XXXXX scored 61 indicating that headaches are having an impact on all aspects of his life.

On the **OREBRO MUSCULOSKELETAL PAIN QUESTIONNAIRE** scores above 130 are indicative of extremely high risk of chronic disability and low likelihood of returning to work now or in the foreseeable future. Mr. XXXXX scored 141.

Patient: **Mr. XXXXX**
Date of Report: **Date**
Date of Loss: **Date**
Date
Evaluator: **Dr. J.H. Ennis, Psychiatrist**

His score on the **SF36** is:



The SF-36 contains 36 items that, when scored, yield 8 domains. Physical functioning assesses limitations in physical activities, such as walking and climbing stairs. The role physical and role emotional domains measure problems with work or other daily

activities as a result of physical health or emotional problems. Bodily pain assesses limitations due to pain, and vitality measures energy and tiredness. The social functioning domain examines the effect of physical and emotional health on normal social activities. Mental health assesses happiness, nervousness and depression. The general health perceptions domain evaluates personal health and the expectation of changes in health. All domains are scored on a scale from 0 to 100, with 100 representing the best possible health state. Summary scores for a physical component (physical functioning, role physical, bodily pain and general health perceptions) and a mental component (vitality, social functioning, mental health and role emotional) can also be derived.

The patient's score is compared to a large, cross country cohort of patients with chronic non-cancer pain. Mr. XXXXX's rating of his pain is 'better' than that of the cohorts from the U.S.A. and Australia. He also reports that his social functioning is better than the patients found in these groups. On all other subscales, Mr. XXXXX scored less than the comparison cohorts and this includes his total score. This indicates a poor level of functioning

This result suggests that Mr. XXXXX might not have understood the questions asked when the test was translated into Mandarin Chinese.

Cognitive Ability:

On the **MONTREAL COGNITIVE ASSESSMENT** the patient scored 28 out of 30 indicating no significant cognitive issues.

Malingering:

On the **REY 15 ITEM MEMORY TEST,** the patient scored 12 out of 15. This is an acceptable score indicating that Mr. XXXXX is not intentionally feigning symptoms of cognitive problems.

Summary of Findings:

Psychometric testing does not reflect Mr. XXXXX's report of pain and reduced functioning, nor his clinical presentation. The tests indicate that there is no significant psychopathology other than a low clinically significant level of somatization. This finding is not consistent with the patient's clinical presentation. He does not have catastrophic thinking on testing, but on clinical examination, there is clear evidence of such thinking. He described himself as disabled and crippled by his injuries, incapable of doing any physical activity for any length of time. His score on the Oswestry Back

Pain Questionnaire does indicate that he perceives himself as crippled as a result of back pain. However, based on his clinical presentation, I did expect a higher score on this test and on the Neck Disability Questionnaire which indicates that he perceives himself as severely disabled as a result of neck pain. His level of function is noted to be reduced, however although his score on the Pain Disability Index is higher than typically seen in patients involved in litigation, it is only slightly elevated. This does not reflect his description of his function. The only tests that are congruent with his clinical presentation are the Orebro, and the Hand and Spine Sorts. The Orebro indicates that there is a very high risk of chronic disability and a low likelihood of return to work. On the Sorts, Mr. XXXXX perceives himself as being below a sedentary level of work capacity. All test results should be considered with some caution given that they were not in Mr. XXXXX's first language. The test questions had to be translated to him.

Patient:	**Mr. XXXXX**
Date of Report:	**Date**
Date of Loss:	**Date**
	Date
Evaluator:	**Dr. J.H. Ennis, Psychiatrist**

SECTION III

The information in this section derives solely from the available medical-legal brief.

REVIEW OF AVAILABLE DOCUMENTATION:

Notes that are handwritten and photocopied will be commented on if they are completely legible. They will not be commented on if parts are legible only. Documents will be commented on only if they are complete and no pages are missing.

Acupuncture Notes:

The primary documents are handwritten in a language other than English and therefore cannot be commented on.

Records of Dr. LLLLL from date:

On date the patient is reporting pain in the forearms related to working as a machine operator. He has pain from the elbow to the wrist. He was advised to lift no more than four pounds.

A note from date states Mr. XXXXX continues to report pain in both wrists and has low back pain with bending. He had some hand pain previously treated. It states that this problem was work related. The patient was given a note for massage therapy.

A note from date states Mr. XXXXX is presenting with low back pain. The patient was given a back care sheet and advised to do pelvic tilts.

A note from date notes that Mr. XXXXX was involved in a motor vehicle accident three days previous

There is episodic contact with primary care physician prior to the accident. In total there appears to be seven primary care notes prior to the accident from date until the date of the accident..

In the note from date it is reported that Mr. XXXXX's car was hit on the right side. He was driving slowly and he reports that he was "hit by an air bag". He has low back pain, left shoulder pain and right sided chest and neck pain. He has localized tenderness in the back of the neck. He was given a recommendation for massage therapy and diagnosed with soft tissue injuries and was told to be off work until the following Monday.

A note from date states that Mr. XXXXX has gone to massage therapy and was feeling better. The neck range of motion was improved and there is now slight reduction in range of motion of the neck. He was requesting a note for his work from date. The patient is diagnosed with soft tissue injury. It is reported that the work may not pay for the patient's time off because the injury was not a severe one.

A note from date states the patient's neck pain continues. X-ray showed degenerative disc disease particularly at C6-7. Pain is worse on extension and he has localized tenderness over C6-7. Recommendations are made for an MRI and soft collar for the neck and the patient is advised to be off work until the MRI is completed.

One can see the subtle beginnings of the development of disability. The patient is told to remain off work and he is given a soft collar. The use of a soft collar is likely to increase neck weakness and pain. Passive treatments have been initiated such as massage therapy.

A note from date states the patient continues to have pain in the neck and was receiving massage therapy. He was reporting numbness in the palm of the hand.

Symptoms are starting to increase, not decrease as would be expected from a physical injury.

A note from date states Mr. XXXXX was in Location the previous month and had massage treatments there. He was complaining of pain in the neck. He was tender to touch at the base of the neck with reduced range of motion in all directions. By way of example, flexion was described as 80% of normal. He was given Tylenol #2 prn and a note for work to be away from work and recommendations are made for physiotherapy.

The patient had 80 percent normal range of motion during the examination in date. He had no movement during my examination today. This is not the characteristic natural history of soft tissue injury.

A note from date states Mr. XXXXX was requesting more time away from work. The patient is going to be off of work until date.

A note from date states that it is the patient's fifth return to work and neck range of

motion is full but he has pain in extension.

A note from Dr. XXXX states “unfit to work until date".

A note from date states that Mr. XXXXX was requesting a note for work for modified hours in order to continue in physiotherapy. The patient had localized tenderness at the base of the neck and complaining of spasm across the shoulders. “This man has abnormalities in the bones of his neck, and neck and shoulder pain following a car accident. He would be able to get back to work better if allowed to gradually increase his length of time at work per day. Please allow him to begin in four hours per day and gradually increase to regular hours.” (sic)

A note from date states there is no improvement since last seen and there are no four hour positions at work. The work place was requesting a note outlining exact restrictions.

A note from date states that it would appear that the workplace is willing to make accommodations.

A note from date reports that shoulder pain is resolved with massage therapy and neck pain is better with acupuncture but comes back. The patient is being treated with Robaxacol tid.

A note from date states the patient is still complaining of neck pain. He has normal range of motion but pain with extension and flexion. He was not at work at the time of the assessment.

A note from date states the patient is still off work and neck pain is unchanged.

A note from date states the patient is getting regular nose bleeds once per week. It was explained to him that the nose bleeds are most likely not related to the accident.

A note from date states the patient has a single episode of dizziness, complaining of numbness in the left index finger. The plan is to “wait and see what happens”.

A note from date reports ongoing neck pain. He is getting GI upset with Robaxacol. The patient is going to be given a trial of Nortriptyline and “duragesic”.

Typically, Duragesic should not be used in an opioid naive patient. Twenty five microgram patch of Duragesic is equivalent to at least 130 mg of morphine.

A note from date states the patient was involved in a second accident on date. He was hit from behind when he was stopped at a cross walk. He was complaining of pain in the neck, right shoulder, arm, numbness in the hand and pain in the right knee. He hit his knee on the dashboard. He was given recommendations for physiotherapy, massage and acupuncture.

A note from date states the patient is now using Phentanyl 75 micrograms and "needs Tylenol #3 for break through in the middle of the night". He reports feeling dizzy after changing the patch. The patient is also being given Nortriptyline 10 mgs increased to 25 mgs qhs.

A note from date there is a discussion about the importance of exercise "for easing pain".

Exercise does not "ease pain". Rather it improves a patient's general fitness.

A note from date indicates the patient works as a lead hand machine operator. He can stop mowing the lawn or doing vacuuming in the home. He has pain in the right knee, upper and low back, neck on the right side with radiating pain down the right hand with numbness in the index finger. He was going to physiotherapy and stopped massage therapy one month previously. It is noted that the pain in the right knee "only started two weeks after" the accident.

A note from date states there is a letter from a Dr. XXXXX thinking that the patient should return to work. There is a refill of Tylenol #3 and Phentanyl patch he did give to him and explained "addicting meds, should try to cut down".

X-ray of the Colon with Double Contrast dated:

No abnormalities identified.

MRI of the Cervical Spine dated:

Straightening of the lordosis was noted related to muscle spasm. There is spondylitic change at C6-7 with bilateral foraminal stenosis.

There is central disc herniation at C5-6 and C7 to T1 with no impression on neuro structures.

X-ray of the Cervical Spine dated:

Mild degenerative disc disease seen at C6-7 with minor encroachment on the intervertebral foramen bilaterally. The rest of the examination is normal.

Report by Location Physiotherapy completed by L. XXXX (physiotherapist) dated:

It is stated that the initial assessment revealed chronic neck pain which increases with movement and headache. There was reduced range of motion of the cervical spine and increased tone and tenderness in the upper fibers of the trapezius, levader scapulae, suboccipitalis and scalenes. She reported there were positive upper limb tension tests in the left side involving median ulnar and radial nerves. There was right upper extremity weakness and decreased extension of C6-7 and elevated first second rib on the left. Treatment is going to focus on "modalities for pain control" and exercise as well as postural training.

Report by Location Physiotherapy completed by L. XXXX (physiotherapist) dated:

Mr. XXXXX was described as having a WAD II injury. The patient had been attending two times per week. Initially there was good improvement in "pain control and range of motion". The patient was reporting improved sleep and it was undisturbed. Since he returned to full-time work duties there has been a progressive increase in pain. He is finding his work duties difficult to manage. The assessor was wondering about a gradual return to work process.

Letter from Dr. XXXX (primary care physician) dated March 4, 2008:

"In general terms, Mr. XXXXX is fit and was therefore fit to return to a job. Specific restrictions meant that the job he could do would require no flexion and extension of his neck on a repetitive basis. Lateral rotation was also restricted. If a job with these restrictions was available he would be fit to return to work." "He had significant restrictions in flexion/extension and lateral rotation of his neck. This improved with physiotherapy but when he returned to work, his symptoms recurred. Otherwise, he is fit. In order to return to work, he would require a job which did not involve a repetitive flexion or rotation of his neck. Lifting of objects less than ten pounds occasionally would be possible. Work above his head would also not be possible".

Report by K. XXXX (chiropractor) dated:

Upon initial assessment the patient had 30% reduction in range of motion of the neck with discomfort in the chest and pain in the low back. It is reported that Mr. XXXXX

maintains steady progress with massage therapy and was able to return to work but soon after his return to work he had an increase in symptoms. He again took a leave of absence from work on the recommendation of his primary care physician and he has started massage therapy again with improvement by 20% at this point in time.

Report by R. XX Location Acupuncture Clinic dated:

The note basically confirms that the patient is receiving acupuncture treatment and receives some relief from the treatment.

Report by Location Physiotherapy completed by L. XXXX (physiotherapist) dated:

Mr. XXXXX reports constant pain at the base of the neck. He gets three hours of relief with medication and cervical traction provides him temporary relief. Since going back to work his pain has increased. The assessor states that there is “positive pain reproduction” with median ulnar nerve tension tests.

Report by R. XXXX (neurologist) dated:

In terms of past medical history there is no significant past medical history and nor was the patient using any medications prior to the accident. He was working full-time as a machine operator at location. He did try and return to work but was unable to manage. He has been unable to resume most of his pre-accident activities within the home.

On examination cranial nerve examination was normal and motor exam showed normal tone in the upper and lower extremity. Examination of power was normal and there was no evidence of atrophy or vesiculation. There was diffuse give way weakness in the entire right upper extremity with normal initial contractions. Sensory examination was normal with the exception of the right second digit where he reported decreased pin prick appreciation. Reflexes were intact and normal. The toes were down going. Fine finger movements and fine foot movements were slow but normal. Finger to nose testing was normal and tandem gait was normal. Rhomberg was negative and Tinel’s and Phalen’s signs were positive.

It was concluded the patient was involved in an accident on date. He hit his head but did not lose consciousness and there was no retrograde or anterograde amnesia. It was his opinion that the patient’s problems with pain were non neurologic other than the tingling of the right second digit. This is most consistent with an early degree of carpal tunnel syndrome as is demonstrated by the positive Tinel’s and Phalen’s sign. It is stated that “this began one week after the motor vehicle accident. The temporal lag is incompatible with traumatic injury”.

It is concluded there is no primary neurologic injury. From a neurological point of view the patient did not have a substantial inability to perform the essential tasks of his job or house keeping or home maintenance.

Occupational Therapy In Home Functional Assessment completed by T. XXXX (OT) dated:

At this point in time the Mr. XXXXX is involved in physiotherapy, massage and acupuncture. The patient is independent in self care although he has increased pain with tasks that require him to bend or move his neck or use his right arm. The patient is able to perform grooming tasks. He does require some assistance with nail care. He is having difficulty using chop sticks. Therefore he is now using a spoon. He also has difficulty cutting with a knife. The assessor reports that Mr. XXXXX has difficulty sitting for long periods of time. He was able to go up and down a set of stairs and he was able to stand for approximately 30 minutes.

In terms of work Mr. XXXXX had been working for the same company for 15 years. His job involved picking up and moving pieces from one machine to a table where he cleans each piece, lifts it and puts it into another machine. The patient was working five to six days per week nine to ten hours per day prior to the accident and he often worked overtime. He did try and return to work but his symptoms increased. Prior to the accident the patient did most of the house keeping tasks because his wife had a work related injury to her neck and back. The patient is completing some of the pre-accident tasks “despite increased pain and difficulty”.

The assessor states that Mr. XXXXX has functional limitations in his ability to complete personal care fully and complete house keeping and home maintenance and to return to work. Recommendations are made for occupational therapy input and assistive devices.

Report by J. XXXX (chiropractor):

The accident is described as well as Mr. XXXXX’s treatments and current complaints. He had reduced range of motion on examination of the cervical spine. Straight leg testing was within normal limits for the left upper extremity but reduced in the right. Hand grip was 12, 15 and 14 on the right and 65, 70 and 66 on the left. Rapid grip exchange revealed 80 pound capability on the left and 37 pounds on the right. Pinch test in the cervical and thoracic region was positive for over reaction. There was reduced range of motion of the lumbar spine in all planes. However the patient could perform heel and toe walking. Sacroiliac compression was reported as tender. Straight leg raising in the sitting position was 90 degrees with no pain. In the supine position it was 40 degrees due to pain. There was evidence of a mild hypertonicity in the

quadratus lumborum area and severe pain was reported with jump sign present. Simulated axial rotation was positive for reproduction of low back pain.

Mr. XXXXX has reported only temporary relief with treatment without objective evidence of ongoing accident related impairment found in the examination. It was stated that examination was inconsistent with positive simulation tests and discrepancies between sitting and supine straight leg raising. There was submaximal effort on hand grip testing and non anatomical numbness. It is stated that the patient presents with nonphysiologic pain that is non responsive to conservative care and therefore an OCF treatment plan for additional chiropractic care was not considered reasonable or necessary.

It should be noted that the assessor did not provide any recommendations for further treatment as is typical for DAC Assessments.

Consultation Report by J. XXXX (neurologist) dated July 21, 2008:

Dr. XXXX describes the accident in brief. Immediately after impact it was felt that Mr. XXXXX did not require assessment at a hospital and he was driven home by his wife's sister-in-law. When Mr. XXXXX woke up the following morning he had pain in the neck, shoulders extending into the right arm and low back. He saw his family physician and had a cervical spine x-ray on November 15th which showed mild degenerative changes at C6-7. Prior to the accident he had occasional low back pain. At the time of this assessment he could walk 30 minutes and he stated his improvement was 50%. He had physiotherapy without significant positive result. He has had massage therapy, chiropractics and acupuncture.

Mr. XXXXX's biggest problem was neck pain radiating into the right shoulder and hand. The next big problem was low back pain and his last problem was pain affecting the foot. He also had problems with fatigue in the region of the right wrist. He was right handed. The foot pain started one week after the accident.

Examination did not reveal any clear neurologic deficits. There was marked tenderness to palpation over the cervical paraspinal muscles and middle trapezius and lumbar region. There was restriction of movement in the lumbar spine. Straight leg raising in the supine position was 90 degrees on the left and 70 on the right. In the sitting position it was 90 degrees bilaterally. There was give way weakness on examination with power in the lower extremity. He could not walk on heels or toes complaining of low back pain. He had full movement of the shoulders although it was associated with pain. Hand grip on the right side was one pound and on the left three and a half pounds. Norms for this test would have been into the 10-14 pound range. He had give way weakness at the right wrist and with muscle strength testing.

Mr. XXXXX rated his pain as 10 out of 10 and back pain is rated as 5 out of 10. The examination did not show evidence of a neurologic deficit and "hopefully his symptoms will lessen over time".

It was concluded that Mr. XXXXX had developed chronic pain in the neck and back. It was also noted that without input from the daughter in this case the examination could not have been done due to language barriers.

Report by Mr. KKKKK dated:

The question asked is has the insured's condition reached pre-injury status. The assessor's response is no. The other question asked is has the insured reached maximum medical improvement. This was outside of the assessor's scope to respond to the question. It was asked whether or not the patient has a substantial inability to perform the essential tasks of his pre-accident employment. It was recommended that the patient be examined by an orthopedic surgeon or physiatrist. It was asked whether or not the patient suffered an inability to perform housekeeping and home maintenance. It was the assessor's opinion that he did and that he would require four hours of housekeeping and home maintenance.

Report by Location Physiotherapy completed by L. XXXX (physiotherapist) dated:

Mr. XXXXX is continuing a home exercise program independently. He now reports intermittent low back pain. He continues to have constant neck pain.

Report by Mr. KKKKK dated:

This is in regards to a treatment plan for OT input. It was concluded that the treatment plan was partially reasonable. He required a bath stool. However the occupational therapy intervention that was proposed was not considered to be required at "this time".

It was stated that Mr. XXXXX demonstrated that he was independent and safe in transfers. Mr. XXXXX reported that physiotherapy had already taught him about pacing, task modification, body mechanics and energy simplification.

In my opinion, Mr. XXXXX should have demonstrated the skills he stated that he learned. The patient did not report having any of these skills during my examination. Unless the skills were taught in his own language with significant behavioural input, in my opinion, it is unlikely that he would have learned the skills noted above.

Mr. XXXXX did demonstrate some tasks such as vacuuming and sweeping. He was observed to perform them safely and within his limits.

Patient:	**Mr. XXXXX**
Date of Report:	**Date**
Date of Loss:	**Date**
	Date
Evaluator:	**Dr. J.H. Ennis, Psychiatrist**

Consultation Report by D. XXXX (physiatrist) dated:

Dr. XXXX was asked to provide an EMG. He did a clinical examination and EMG study. Primary finding on physical examination was diffuse pain with light touch through the neck and shoulder girdle. This pain was reproduced by lightly touching skin and subcutaneous tissue. He had pain when he elevated his right shoulder.

In terms of the EMG he stated there was no explanation based on the study for the numbness of the patient's index finger. There was no evidence of carpal tunnel syndrome or evidence of any active denervation. The only finding was of scattered large polyphasic potentials in the first dorsal interosseous and the extensor digitorum communis. This could represent a very stable, mild, chronic C8 radiculopathy. Dr. Harvey concluded the patient might be a candidate for assessment in a chronic pain type of facility.

Discharge Report by Location Physiotherapy completed by L. XXXX (physiotherapist) dated:

Mr. XXXXX began treatment in physiotherapy date with initially "good improvement". The patient returned to work date on full duties but his symptoms gradually increased and the employer could not accommodate the patient and the patient has been off work since mid March. Since that point in time there has been no improvement. There is some temporary relief of headache and neck pain with traction.

Orthopedic Assessment by J. XXXX (orthopedic surgeon) dated:

Dr. XXXX reviews available documentation. He reviews the accident and Mr. XXXXX's current symptoms. At this point in time Mr. XXXXX was mowing the lawn using a power mower and he was doing snow removal with a snow blower. He and his wife prepared meals together and did shopping together and he purchased a small vacuum cleaner that he used with the help of his daughter. His wife does the laundry.

Primary findings on physical examination include neck tenderness with withdrawal response to palpation. The range of motion of the cervical spine was reduced in all planes. There was reduced range of motion of the right shoulder. On lumbar spine examination he could bring his fingertips to mid thigh. Extension was decreased. Limitation was as a result of pain and he had hypersensitivity of the skin over the midline of the low back. He was able to sit with his legs completely extended but on formal straight leg examination it was to 60 degrees bilaterally. He had reduced range of motion at the right knee. There was tenderness in the first metatarsal phylangeal joint on the left. He walked slowly. At this time there was no limp. He walked on his

toes and heels with encouragement. He could stand on his foot satisfactorily and he could squat fully.

Mr. XXXXX's findings continue to deteriorate over the course of time. This is not in keeping with the natural history of a soft tissue injury.

Dr. XXXX states that there has been a significant reduction in Mr. XXXXX's symptoms but there was still findings on physical examination of reduced range of motion of the axial spine. He stated that the patient should continue to use an active home program and start a gradual rate of return to full activities over a four to six week period of time. He concludes the patient has not reached maximum medical recovery.

Ambulance Call Report dated:

Mr. XXXXX was the driver of a small SUV that was stopped and rear ended at a slow speed. It was noted the patient had limited English but he indicated pain in the upper lumbar spine and the cervical spine around C6-7. The daughter reported that he had injured these areas in a motor vehicle accident the previous year. It is reported the patient has a previous injury to the neck and back from a motor vehicle accident the previous year. He was given a cervical collar at that time. The only findings were pain to C6-7 region although the patient was unable to describe the pain *(most likely due to issues related to language)*. In terms of sensation there was no change and there was not change to mobility. He was put on a backboard.

Emergency Room Cover Sheet dated:

This is a motor vehicle accident. The patient was seat belted. Air bags did not deploy and he was rear ended while at a stop light. He was complaining of back pain and neck pain. The patient was given reassurance and discharged.

Plain Film X-ray of the Cervical Spine dated:

Marked end plate osteophytes at C5-7 and minor osteophytes also noted at a few unconvertible joints. Moderate disc space narrowing at C6-7.

X-ray of the Lumbar Spine dated:

Minor end plate marginal osteophytes noted at all lumbar levels.

Patient:	**Mr. XXXXX**
Date of Report:	**Date**
Date of Loss:	**Date**
	Date
Evaluator:	**Dr. J.H. Ennis, Psychiatrist**

Consultation Report by D. XXXX (physiatrist) dated:

Based on the study there is no explanation for Mr. XXXXX's numbness in his hand. There is no indication of carpal tunnel syndrome or evidence of active denervation. The only finding are scattered large polyphasic potentials in the first dorsal interoscias and the extensor digitorum communis which could represent very mild stable chronic C8 radiculopathy. Recommendations are made for flexion extension films. Ultrasound of the shoulder may also be useful to assess the rotator cuff. His presentation was of diffuse wide spread pain elicited with light touch of the skin and he "might be a candidate for assessment at a chronic pain type of facility".

I do agree with Dr. XXXX's recommendations. However, given that Mr. XXXXX does not have facility with English, it is unlikely that he can be successfully treated in a pain program. In my opinion, he would be a good candidate for a multidisciplinary pain program, but all such programs in the region are conducted in English and patients cannot be accompanied by translators.

X-ray of the Right Knee dated:

Normal.

X-ray of the Right Knee dated:

Normal examination.

Report by L. XXXX (physiotherapist) dated:

Mr. XXXXX was having physiotherapy input but there had been little progress over the previous two months. There was temporary relief for traction but it was not long lasting. The patient had constant numbness in the second digit of the right hand and pain in the neck into the right shoulder. He had reduced range of motion of the cervical spine. He had decreased movement of the right shoulder. He was reporting a weak right upper extremity on resisted testing. There was reduced range of motion of the lumbar spine. Lumbar traction provided some relief. The patient was receiving input from a Chinese acupuncturist who was also performing massage therapy. It was reported that there had been significant improvement and that mobility of the neck, back and shoulders were within normal limits. However the relief did not appear to be long lasting. The patient was discharged with a home exercise program.

It is reported that Mr. XXXXX's range of motion of the cervical spine returned to within a

normal range. However, upon reviewing documentation, his range of motion continues to reduce over the course of time.

Job Assessment, Insurer's Examination dated completed by S. XXXX(OT):

It is noted that Mr. XXXXX's pre-accident job is no longer available because the line is no longer running. However the company was optimistic that they could accommodate return to work for Mr. XXXXX once he was cleared by his treating physician. They require minimal restrictions. They would also prefer that he return on full-time hours but they may be able to negotiate gradual hours. At this time people were working 8 ½ hour shifts.

Orthopedic Assessment by J. XXXX (orthopedic surgeon) dated:

During the assessment Mr. XXXXX stated he would be willing to return to work and he was waiting for his doctor's orders to do so. It was Dr. XXXX's opinion that Mr. XXXXX should return to work full-time with modified activities and gradually increase the activities over a period of six weeks. Restrictions are related to neck and low back. It is stated that one should keep in mind that he had significant symptoms in the neck and low back immediately prior to the motor vehicle accident of date as a result of a previous motor vehicle accident of date. "The previous issues are related to his present disability."

MRI of the Spine dated:

Spondylolitic change at C6-6 with canal stenosis but no cord abutment or deformity. There is bilateral foraminal stenosis.

Occupational Therapy Functional Assessment completed by T. XXXX (OT) dated:

It is concluded that Mr. XXXXX was having ongoing symptoms after his first accident but following the second accident he developed increased neck and low back pain, and right knee pain, decreased range of motion of the right knee, increased numbness and tingling down the right arm, significant weakness in the right hand, significant impaired coordination of the right hand and significantly impaired range of motion in the right index thumb. It is concluded the patient has changes in MRI findings with a moderate sized disc herniation at C7 T1 and flattening of the anterior aspect of the spinal cord. There has been an impact on the patient's level of functioning. This has had an impact

on all aspects of his day to day functioning.

It is reported that after the first accident Mr. XXXXX had returned to some housekeeping home maintenance tasks but since the second accident has been unable to do these tasks and therefore he requires more assistance in housekeeping and home maintenance. Occupation therapy is recommended as well as housekeeping assistance four hours per week and additional assistive devices.

Report by P. XXXX (primary care physician) undated:

It is reported that Mr. XXXXX was involved in an accident on date sustaining whiplash. MRI showed osteoarthritic changes and disc herniation at C5-6 and C7 T1 but without compression of the cord. In date the patient tried to return to work but found increased pain rendered him unable to continue. On date Dr. XXXX wrote the company outlining the patient's limitations. The patient was referred to Dr. XXXX (neurologist) in date. No neurologic abnormalities were identified but EMG showed chronic radiculopathy. By date there had been no appreciable change.

On date the patient had a second accident. It was at this time he was started on the duragesic patch. It is stated that the patient was seen at a pain clinic in Hamilton but it was decided "that they could not help him because his English was not good enough". MRI was repeated showing a moderate disc herniation at C5-6 with no deformity of the cord and C7 T1 with flattening of the cord. It was reported that he continued to be disabled by pain in the neck and right knee and there was limitation in his capacity to function within his home.

By date the patient understood that there was no more funds available for physiotherapy. "This meant he continued to have significant pain."

There is no evidence that ongoing physiotherapy is likely to have a positive impact on chronic noncancer pain.

He did home exercise and attempted to return to work but was unable to work longer than three hours. There apparently is an effort to begin a work hardening program and she recommended referral to a pain program.

It should be noted that the presence fo disc herniation on MRI does not indicate that this is the cause of the patient's back pain. It has been well documented that patients without back pain can have significant back pathology. Commentary about the significance of the axial spine imaging is best left in the hands of an expert in physical medicine.

Report from Location After Hours Clinic dated:

The note states that Mr. XXXXX presents with low back pain, neck pain, headaches and blurred vision. The previous MVA is noted and at this time the patient is using Fentanyl patch 75 micrograms and Tylenol #3. The rest of the document is not legible.

X-ray of the Thoracic Spine and Lumbar Spine dated:

Moderate degenerative disc disease noted throughout the majority of the thoracic spine. No significant abnormalities are seen in the lumbar spine or SI joint.

Functional Abilities Evaluation completed by C. XXXX (kinesiologist), K. XXXX (OT) dated:

By way of example when the patient was asked to lift, he had increased pain from his neck to low back while lifting 8 pounds and the test was stopped at 11 pounds. While lifting three pounds he reported that he had increased pain. The patient was unable to perform tests involving crawling, kneeling or squatting. In terms of walking the patient stated he could walk up to ten minutes.

In conclusion it is stated that the patient's physical strength was limited to one to ten pounds up to 11-20 pounds. He demonstrated medium strength ability when pushing and pulling to a maximum of 35 pounds. Overall he demonstrated limited physical strength. There was a job assessment done of Mr. XXXXX's job as a lead hand for Easton Manufacturing. In order for him to return to work there would have to be minimal restrictions because the job requires "a very versatile individual physically". It is concluded that in the patient's current state it is unreasonable to consider him as being a "physically versatile individual". The patient has also been off work for two years. It was concluded that the patient is not "physically ready to attempt a return to work at this time".

Report by V. XXXX (physiatrist) dated:

The accidents are described. The patient's complaints, investigations and treatments are noted.

On physical examination there was some reduced hearing on the right through air conduction. There was tenderness to palpation of the neck muscles. He was particularly tender on the right side showing withdrawal reaction to touch. Neck

movement was quite restricted. There was no evidence of swelling or tenderness of the arms although range of motion of the left was reduced in abduction to 106 degrees and to 120 degrees on the right. (Normal is 180 degrees). Internal and external rotation was reduced to less than 50% on the left side. Strength showed mild weakness at the shoulder. Reflexes were normal. There was a 30 degree lordosis with tightness and guarding of the paravertebral muscles. There was very limited movement of the lumbar spine with less than 50% normal range. Straight leg raising was positive in the lying position 30 on the right and 45 on the left. Straight leg raising in the sitting position was painful at 90 degrees. Toe, heel and tandem gait walking were all limited due to loss of balance and reports of pain. There was weakness with one leg standing.

It was stated that the patient sustained soft tissue injuries to the head, neck, chest and low back. The patient continues to show impairment of the cervical and lumbar spines with evidence of weakness in the right arm particularly the right shoulder, right thumb and index finger. There is evidence of posttraumatic condromylasia of the knee and possible lumbar nerve root irritation.

In terms of recommendations, MRI of the lumbar spine is recommended. Recommendation for a gym membership is recommended. He did not appear to be a good candidate for psychological counseling or psychologically oriented pain program due to his limited education in English.

In my opinion, it is highly unlikely that a gym membership will have any significant impact on this patients symptoms or level of function.

Independent Medical Evaluation completed by M. XXXX (physiatrist) dated:

Medical records are reviewed.

The first accident is described and the patient reports that he blacked out but he is not sure for how long. His last memory was of air bags deploying. This is in the date accident. His next recollection was sitting in the motor vehicle and hearing voices of passerbys. Initially he felt scared but he was able to get himself out of the car. He was not taken to hospital at that time. Treatment had ended by the time he was involved in his second accident. The patient went through the same treatment as he did from the first accident. He had no psychiatric or psychological input after the second accident.

Mr. XXXXX's subjective complaints are documented. In terms of past medical history there is nothing of significance reported. In terms of personal history the patient was born in Location. He thought that his education was somewhere between grade nine and grade 12 and he came to Canada in 1993. He is married and at this time had an 11 year old child. The patient was independent in his own self care. He did some light cooking and helps dishwashing although at a slower pace than he used to. He does

participate in house work but much less than he did prior to the accident. He does help to carry laundry but carries half loads at a time. He has not resumed cutting grass or shoveling snow. His wife does the shopping for groceries whereas prior to the accident they would go together.

Prior to the accident Mr. XXXXX was working full-time since 1993 as a machine operator. He used a computerized lathe with most of the material that he was handling weighing about 10 pounds. He also repaired machines. He did return to work in date but only lasted for a few hours for a few days and then he stopped.

On examination range of motion of the cervical spine was about 50% of normal. Pain was the limiting factor and he was locally tender on palpation throughout the neck. There was no wasting around the shoulder and there was normal muscle bulk and tone in the upper extremity and deep tendon reflexes were 1+ and equal bilaterally. Strength was intact. There was a decrease of appreciation to light touch throughout the entire right arm. Lumbar spine showed normal alignment with reduced range of motion. Passive pelvic rotation reproduced complaints of low back pain. There was diffuse tenderness over the lumbar spine. In the sitting position straight leg raising was within normal limits. In the supine position on the right there was reproduction of low back pain. Examination of the lower extremity was normal and the patient was neurologically intact. There was pain on patellofemoral compression.

It was the assessor's opinion that the results of the second accident, aggravated pre-existing conditions with respect to neck pain radiating into the right upper extremity ending with numbness in the right index finger and it also aggravated the complaints of back pain and headache with a new onset of right anterior knee pain.

There was quite marked limited range of motion of the lumbar spine associated with pain and diffuse tenderness. He could not explain the fact that in the sitting position straight leg raising was normal but in the supine position there was reproduction of low back pain and flexing of the hip and knee to 90 degrees did not relieve the pain.

"I do not believe that there is any underlying identifiable impairment that would explain his marked restriction in range of motion in the lumbar spine, but rather due to his complaints of pain." Again, the finding of decreased appreciation to light touch of the entire right leg could not be explained by the assessor. He also notes the presence of a patellofemoral syndrome which in fact is a subjective complaint, and "the presence or absence of such pain does not correlate with any findings on imaging with respect to condromylasia patelli".

The patient is diagnosed with ongoing chronic pain rather than any specific musculoskeletal impairment. The prognosis is considered worse as time goes by. The assessor could not find presence of a specific identifiable underlying musculoskeletal

impairment but rather the presence of chronic pain. It is concluded that the patient's pain complaints were all present prior to the motor vehicle accident except his right knee pain. There has been no significant change in level of function since the date accident.

Report by M. XXXX (massage therapist) dated:

It is stated that Mr. XXXXX can "only watch TV, read or drive for half hour at a time before he has to use some sort of Chinese ointment on his affected muscles". His gait is described as slow and guarded. The patient was been going for regular massage therapy and he finds the therapy gives him two days of relief lowering pain from 8 out of ten to 5 out of ten.

There is no significant evidence in the medical literature that massage therapy will have a significant clinical impact on chronic noncancer pain.

Report by P. XXXX (physiatrist) dated:

The first accident is described as is the second. Mr. XXXXX reported a 20-30% improvement by the time the second accident occurred. The patient reported he has not improved since the second accident which he characterized as the more severe accident. His current complaints are noted. The patient did not report any significant pre-accident problems. He did not report a previous history of headache, neck pain, neurogenic leg pain, knee pain or emotional problems and he was not taking any medications prior to the first accident.

In regards to function the patient required assistance from his wife from time to time in regards to dressing and undressing and using a long handled scrub brush in the shower. Prior to the first accident he managed all indoor chores apart from cooking in the home and he did all household maintenance. Since the first accident he has been unable to do household chores other than mopping the floor from time to time and going shopping with his wife.

The patient was employed as a machine operator and team leader and had been with the company since 1993 until 2007. He has never worked in any other capacity in Canada and he has not resumed any type of gainful employment since the accidents.

Mr. XXXXX did not participate in sports or exercise prior to the first accident. He would socialize with family and friends on weekends and enjoyed going out for dinner or shopping with his wife and daughter. He does this on better days only since the accident.

Patient:	**Mr. XXXXX**
Date of Report:	**Date**
Date of Loss:	**Date**
	Date
Evaluator:	**Dr. J.H. Ennis, Psychiatrist**

Physical examination described the patient as pleasant weighing 130 pounds and 160 centimeters in height. He did demonstrate pain behaviours. Cervical posture was poor and there was diffuse tenderness without evidence of spasm and there was limited movement of the neck to only a few degrees in all directions. The right upper limb was described as diffusely tender to very superficial palpation. There was no evidence of inflamation and elevation of the arm was limited to 70 degrees.

There was a mild lumbar lordosis. There was diffuse tenderness without muscle spasm. Movement was limited to only a few degrees in all directions. He reported pain with simulated axial rotation. Passive movements of the right hip elicited reports of low back pain.

Percussion of the median nerve (Tinel sign) elicited a severe local pain reaction on the right. Bilateral straight leg raise to 90 degrees was noted in the sitting position which was associated with mild low back discomfort. He reported severe low back pain on straight leg raise to 30 degrees in the supine position. Strength was diffusely decreased in the right upper and lower extremity without a myotomal pattern and sensation was also decreased along the entire right side of the body with the mid line split.

Dr. XXXX found no objective documentation of a significant head injury or cognitive impairment as a result of cerebral trauma. However he did wonder about the “sincerity of his reported symptoms and excessive pain behaviour, the non organic signs of symptom magnification identified today suggests a strong psychological component to his reported pain experience”.

The presence of symptom magnification precludes an accurate determination of true physical impairment. Psychological factors may be a major barrier.

In conclusion Dr. XXXX states “unfortunately, the intensity of the non organic signs/pain behaviours that Mr. XXXXX exhibited today precluded an accurate determination of physical impairment and suggests that psychological factors could represent the major barrier . . . “.

Report by N. XXXX (physiatrist) dated:

Dr. XXXX was provided with additional documentation. He concluded that the presence of the documentation did not alter his previous opinion. He stated that the accident of date caused injuries that preclude the patient from returning to his pre-accident employment or engaging in his pre-accident activities within the home. The primary issue for the patient is ongoing chronic pain.

Patient:	**Mr. XXXXX**
Date of Report:	**Date**
Date of Loss:	**Date**
	Date
Evaluator:	**Dr. J.H. Ennis, Psychiatrist**

Psychological Report by L. XXXX (psychologist) dated:

The first accident is described as well as the second. Mr. XXXXX's primary complaints are reported. His level of function is examined. Treatment to date has also been described. The patient's personal family background are reviewed in detail. In summary the patient was born in Location. He came from a poor family. He worked during the day while going to school at night from an early age. During the war the patient was a child and he saw deaths and bombings. He saw bodies lying in the street. He denied that this had any emotional affect on him.

When the Vietcong took over rule in 1975 it was difficult for the patient and his family. They were impoverished and activities were restricted under the communist. He avoided forced labor because he was an ethnic Chinese. He denied being personally threatened or oppressed. His father however died in an accident with the Vietcong military truck when the patient was a young teenager.

The patient is the eldest of a sibline of four with two younger brothers and a sister. As the eldest he was obliged to support the family. His brothers live in Location and he has a sister in location. The mother continues to live in Location. He has ongoing contact with her through the Internet. Her health has been deteriorating. He denied any history of abuse or neglect stating that children in Location know how to fend for themselves. There was no family history of substance use.

Mr. XXXXX met his wife in Location in the mid 1980's. Her brother moved to Canada and he sponsored her in 1991 and Mr. XXXXX immigrated to Canada in 1993. He has a sense of security living in Canada. He and his wife married in 1994. He described his wife as supportive and understanding.

The patient went to school until about grade nine when the communist closed the Chinese school he as attending. He then went to an underground school for a short period of time but was fearful of being arrested so he stopped going. He did an apprenticeship in electronic repair but did not receive his certificate. He started his own business in Location selling electronic components until he came to Canada and he has been employed at location since coming to Canada.

The patient did display pain behaviours during the assessment. After 40 minutes he requested a break stating he had severe back pain. Documentation is reviewed.

It is reported that the patient has reduced intimacy as a result of pain and low libido. He has problems with memory and irritability. Changes in mood correspond to his level of experienced pain. It is stated the patient denied symptoms commonly associated with depressed mood. There was no evidence of posttraumatic stress disorder. There was no impairment in social function. The family discusses his pain and might massage him with oil in order to lessen his pain. The patient's wife has been off work due to a

workplace injury and he and his wife have been applying for CPP. "This could further focus him on disability issues rather than vocational restoration."

The assessor states that there was a "dearth of symptoms and signs associated with psychopathology . . . ". At the same time psychological and social factors are noted to play a role in the patient's presentation of pain.

The patient is diagnosed with a pain disorder associated with both psychological factors and a general medical condition. "However from a psychological standpoint I believe that Mr. XXXXX is over determined in presenting more pathological pain reaction than other indices suggest . . .".

It is unclear to me what is meant by this statement.

It was noted that Mr. XXXXX was thinking about returning to work after the first accident but not the second and this assessor concludes from this that "from a psychological standpoint, this suggests that his pain reaction was not entrenched to the degree that he presented after the second car accident". It is reported that resolution or alleviation of his problems "appears to have ended after the second accident".

It is unclear to me what is meant by this statement.

"I believe that both accidents are material in Mr. XXXXX's ongoing pain disorder to the extent that each resulted in physical injury with enduring consequences. . . "

Prior to the accident the patient had positive employment reviews. Approximately two weeks prior to this assessment the patient had learned that his employment had been terminated. His pre-accident position was no longer available as the line was no longer running and had been phased out. However the employer was optimistic that he could accommodate the patient once he was medically cleared but he would need to be able to work on a daily basis.

Support for the conclusion that the patient's pain behaviours were over determined include the fact that his affect and pain behaviours did not correspond and his pain behaviours decreased as the day progressed.

It is unclear to me what is meant by this statement.

He also questioned the efficacy of the patient's medications.

Commentary about medications is not within this assessor's area of expertise.

It was a concern that the patient was using narcotic medications "which could further

compromise functioning in a potentially dangerous job. Therefore I consider him substantially disabled with respect to managing his former employment as he would likely feel unable to perform his work consistently and his medication could pose a safety risk . .. "

As noted above commentary about medications is not within this assessor's area of expertise.

Dr. XXXX goes on to suggest that the patient's pain behaviours could improve if he could engage in an occupation that he was physically capable of managing.

Based on this patient's clinical presentation and history, there is no job that he can manage. He is not even managing his day to day life.

It was suggested that he would need to undergo vocational evaluation involving a transferable skills analysis.

Report by P. XXXX (psychologist) dated:

Psychological testing involved the use of Wechsler, Wide Range Achievement Test (WRAT), Non Reading Aptitude Test, Purdue Pegboard test, Millon Clinical Multiaxial Inventory III, BECK Depression Inventory II, BECK Anxiety Inventory and Pain Patient Profile.

The procedure as to how the tests were given was not described. This is significant given that Mr. XXXXX has limited command of English.

It was reported during testing that Mr. XXXXX was very pain focused, constantly clenching and unclenching his right fist. He communicated almost exclusively through his interpreter. He was cooperative. He had a high score on digit span.

Scores on the WAIS III led to the conclusion that the patient probably has non-verbal information processing difficulties. Only the non verbal test component was given. On the WRAT it is reported that the patient is illiterate in English and has very modest numerical abilities. Math computation was grade 5.9 level at the 14 percentile. On the NATB this is a non verbal test. It indicates that the patient has good spatial aptitude, form perception. His motor coordination, dexterity and manual dexterity were reported as poor.

On the Millon it was concluded the patient was under reporting symptoms. He obtained elevations approaching significance on three scales suggesting that he has become dependent upon emotional support from others, that he tends to be meticulous

compulsive careful individual and he is reporting clinically significant levels of anxiety, stress, tension and depression.

On the BECK Depression Inventory his score put him in the moderate range for depression. On the BECK Anxiety Inventory his core put him in the minimal level. On the Pain Patient Profile he had average depression score and average anxiety score and average somatization score when compared with patients with chronic pain.

It was the opinion of this assessor the patient was presenting with a pain disorder associated with both psychological factors and a general medical condition. He was also diagnosed with an adjustment disorder with mixed anxiety and depressed mood of moderate severity. It is concluded that "psychological counseling with the focus on pain management and depression management is advised".

It is stated that he is a poor candidate for retraining because of his age, history of medical disability and lack of facility in English. "In all likelihood, he has been rendered totally and permanently disabled by his injuries."

Transferable Skills Analysis completed by M. XXXX (Rehabilitation Consultant) and M. XXXX (Manager Rehabilitation Services) dated:

In terms of education Mr. XXXXX completed grade 9 in Location. He would have needed two additional years to complete high school. They were not available to him because of the Location war. He was a student at a Chinese Language school designed for the "working class". The patient's native language is Chinese. He is fluent in Cantonese and has some skills in Mandarin. He has learned Location in school which was compulsory in Location. While working in electric repair shop he took evening courses. He repaired small electrical appliances. He reported being able to understand simple English and he had basic writing and reading skills in English but following the accident he stated that he had difficulty remembering English words. He can write simple English words. He has no computer training or academic upgrading. He did not have formal post secondary school. He was trained on the job in an electric repair shop in Location and in Canada as an operator. He has no apprenticeship training. He participated in factory sponsored training at CN machine set up and repair. He brought in interpreter to his training program. He has not had any safety training and is not involved in any associations. He did have ESL training when he first came to Canada for one to two months.

At the time of the accident Mr. XXXXX was employed at location. It manufactures automobile parts. The patient worked 10 hours per day five to six days per week. He was paid $17.80 per hour as a base salary plus he received team bonuses and additional bonuses for repairs and production. This would total up to $31 per hour. He also received overtime and he had medical benefits.

Mr. XXXXX reported that the job was physically demanding. He started by working at CNC machines which requires constant standing and then went on to repair machines. The most common repair was changing broken cutting blades. The cutting tools weighed 10 kilograms but he could use a crane to move the tools to machine location. He also trained new staff. He trained staff through visual demonstration to accommodate for his limited language skills. Mr. XXXXX reported that his machinery was computerized and required higher cognitive demands. Repairing the machine was considered dangerous. He worked on a team and he was eventually able to obtain a team leader set up operator position. He enjoyed the job and he enjoyed the people he worked with.

Mr. XXXXX indicated he could not return to work because of back pain, neck pain, right arm and shoulder pain and cognitive problems. He did try to go back to work but could not complete his job and after three days he stopped. There are no modified positions for the patient and his job was phased out by the company due to organizational changes. However the company was willing to offer Mr. XXXXX alternative employment if he was physically able to manage it.

It is concluded that Mr. XXXXX has impairments in strength and ability to sit, stand and walk and impairment in upper limb coordination at and above shoulder level. His strength level is for less than five pounds and he is restricted from prolonged upper limb activity at or above shoulder level. The patient's job is no longer available and a functional abilities evaluation concluded that Mr. XXXXX was not able to return to his pre-accident work. He has limited formal education and limited use of English language. As well he has developed skills in problem solving, continuous learning, operation of machinery and tools and working independently and on a team. The consultant was unable to "identify any occupations Mr. XXXXX is qualified for by his education, training or experience".

Pre-Return to Work Support and Facilitation Report by G. XXXX (OT) dated:

The purpose of the report is to provide a work conditioning program. The accident is described as well as Mr. XXXXX's current complaints. His treatment to date is noted as is his social history. It is reported that his wife is on extended disability leave from work due to "fibromyalgia".

The primary barriers that Mr. XXXXX identified for returning to work included perception of pain and disability, worried thinking, fear of harm or re-injury. There was also evidence of "low mood". He was pain focused. A measure for pain focus was used and it was concluded the patient was at a low range of risk. The same was true for measures of re-injury. On measurement of perceived disability, the patient placed in a high risk range.

At follow up Mr. XXXXX was noted to have difficulty with attending to activity and planning and tracking. For example he forgot his book on some occasions. At other times he complained of severe pain. Typically the patient reported increased pain with increased activity. He was observed to be able to sit for 30-45 minutes. He was observed to grimace periodically demonstrating pain behaviours. He appeared "highly invested in physical treatment modalities, though struggled with steady increases in home functioning tolerances".

Mr. XXXXX was involved in a work conditioning program. He attended reasonably regularly and progressed 3.5 hours three days per week with considerable support, distraction and use of a TENS machine on site. Recommendations are made for a home TENS machine and a gym membership.

It was the opinion of Ms. Wright that Mr. XXXXX has received a good work conditioning program along with input in regards to home functioning and there was improvement although his level of function does not support his return to pre-accident full-time work. His "functional abilities are not likely to support even consistent part-time employment . . ."

Orthopedic Assessment by J. XXXX (orthopedic surgeon) dated:

This is a medical legal assessment at the request of the insurance provider. Dr. XXXX reviewed the patient's history. Dr. XXXX reviewed documentation provided to him. Dr. XXXX stated Mr. XXXXX's current symptoms. He notes some of the changes in the patient's function in that he is unable to do the household activities or house care activities as he did prior to the accident.

Findings on physical examination include the fact that Mr. XXXXX walked hesitantly. He described the patient as having a limp on the right lower extremity which varied from time to time and not following any specific pattern. He was unable to walk on the tips of his toes because of pain in the right knee. The right knee tended to give out and buckle. The patient could not walk on his heels because of pain in the right knee and low back. He noted again a giving out of the right knee. However the patient did not fall to the floor. He could stand on one foot but could not go up and down on the toes. He could squat about two thirds of normal with the limitation being knee pain.

Examination of the neck showed moderate tenderness in the right paraspinal and superior border of the trapezius on the right side. Range of motion of the neck was restricted in all planes. He stated that it was more restricted than one would expect from visualization "of the translator of his right side during the interview".

There was reduced range of motion in the right shoulder in abduction and forward flexion. There was pain with external rotation and abduction and extension was normal. He was unable to place his hands behind his head. There was no evidence of

impingement. There was no wasting. There was a decrease in range of motion at the elbow and at the right wrist.

Examination of the low back revealed that he could flex through the fingers just to the lower thigh with the limitation being back pain. Lateral flexion was 25% of normal. There was no evidence of root tension in sitting. Straight leg raising was 30 degrees bilaterally. He could simultaneously straight leg raise without pain. He was able to sit with his knees extended at 90 degrees without pain. Examination of the knee showed reduced range of motion on the right without effusion. The joint was stable. He could not assess crepitation because of guarding.

In summary Dr. XXXX concludes that Mr. XXXXX may have injured soft tissues in the neck and low back as a result of the accident. This occurred in the first accident and may have been exacerbated in the second. He notes a significant degree of non-organic and inconsistent findings suggesting a significant focus on pain and disability. He states that treatment should consist of active program of mobilization, flexibility routines for the neck, low back and right knee. "Passive modality treatments and continuation of his present medications will reinforce his perception of disability and support his focus on pain and self limiting behaviour."

I do not disagree with Dr. XXXX's concerns about reinforcing Mr. XXXXX's belief about his own disability. However it is highly unlikely that an active program of mobilization and flexibility routines will have any impact on this patient's perception of pain and disability.

Dr. XXXX goes on to state the patient should be gradually reintegrated into activities he was doing prior to the accident.

Dr. XXXX states the patient has significant pain focused behaviour, pain magnification and self limiting activities. He also has strain of the neck and low back and there may have been a contusion or strain of the right knee. He states there is chronic pain.

Dr. XXXX states that the patient has not reached his pre-accident medical status but maximum medical recovery has probably been achieved. The prognosis is guarded because of pain focused behaviour, self limiting activities and portrayal of disability.

Dr. XXXX concludes that the patient has sustained a substantial inability to perform the essential tasks of his employment as a machinist. He attributes this to non-organic factors.

The issues facing Mr. XXXXX are psychiatric in nature. This does not mean that they are not organic. It means that they are not orthopedic.

Dr. XXXX concludes that from an orthopedic point of view the patient does not suffer a

complete inability to engage in his employment. However based on transferable skills analysis and in consideration of limitations post MVA, Dr. XXXX "was unable to identify any occupations Mr. XXXXX is qualified for by his education, training and experience".

Dr. XXXX states that Mr. XXXXX does not suffer a complete inability to engage in any employment for which he is suited by education, training or experience. However, given the patient's current limitations Dr. XXXX was unable to identify any occupation that Mr. XXXXX is qualified for.

Report by G. XXXX (OT) dated:

It is stated that Mr. XXXXX is not capable of sustained work in his pre-accident capacity. He was able to manage less than one third of a work week of physical activity. He managed 10.5 hours in a week with the use of verbal coaching, encouragement and a TENS machine. He could not manage sustained physical activity. The patient's lifting capacity is less than 2 kilograms and only to waist level and his pre-accident job requires at least five kilograms. Mr. XXXXX also reports chronic relatively wide spread pain. He avoids activity in order to manage his pain. He had difficulty with upper limb coordination. The patient has been away from the workplace for over two years. There is evidence of dysphoric mood.

Addendum Transferable Skills by M. XXXX and M. XXXX (rehabilitation consultants) dated:

This is a transferable skills addendum. It is the opinion of the assessors that the patient's pre-accident job is unsuitable for Mr. XXXXX. There are other positions they state that he is not capable of managing. They provide a rationale for their conclusions. The assessors were unable to identify any occupation that Mr. XXXXX is qualified for through his education, training or experience.

Report by T. XXXX(OT) dated:

Ms. XXXX did an occupational therapy assessment reviewing the job of inspector and a job entitled "Central Control and Process Operator, mineral and metal processing". It was her opinion that Mr. XXXXX "would not be capable of working in either of these positions full-time or even on a part-time basis".

Report by P. XXXX (psychologist) dated:

Patient:	**Mr. XXXXX**
Date of Report:	**Date**
Date of Loss:	**Date**
	Date
Evaluator:	**Dr. J.H. Ennis, Psychiatrist**

This is in regards to a report by Ms. XXXX who concluded that Mr. XXXXX was capable of performing work either as an inspector or central control and process operator. Dr. XXXX concludes that Ms. XXXX's conclusions may be based on the assumption that Mr. XXXXX was a CNC operator. According to Dr. XXXX this is not the case and he states that Mr. XXXXX was at a "much lower level of factory labour". This involved loading and unloading CNC machines. An inspector requires writing skills and communication skills and Mr. XXXXX was illiterate and innumerate. He needs an interpreter for assessments. It is questionable if he can manage the memory demands of his job. The job requires some high school education and a candidate must be able to follow written instructions and it is the opinion of this assessor that Mr. XXXXX fails in both criteria. Dr. XXXX does not agree with Ms. XXXX's opinion.

Addendum to Functional Abilities Evaluation completed by C. XXXX and J. XXXX (rehabilitation assessors) dated:

Surveillance is reviewed.

I did not have a copy of the surveillance material.

It was the assessor's opinion based on an FAE that Mr. XXXXX was not physically ready to attempt to return to his own occupation. The Human Resource Manager at Location Manufacturing indicated that Mr. XXXXX could have his old job back but he had to have minimal restrictions as the job requires "a very versatile individual physically". Based on the functional assessment it was identified that Mr. XXXXX could perform sitting on an occasional basis, standing on a minimal basis and walking on a minimal basis. Nothing has changed since the patient was last seen and the opinion is unchanged by the surveillance material.

Report by G. XXXX (OT) dated:

This is a document in which Ms. XXXX reviews the surveillance material. After reviewing the material Ms. XXXX reports that it does not alter her previous opinion.

Report by P. XXXX (psychologist) dated:

Dr. XXXX was provided with surveillance material. After reviewing the material he indicated that there was no evidence to be concerned about in regards to Mr. XXXXX's credibility. In addition the data from the surveillance did not alter his previous opinion.

Patient:	**Mr. XXXXX**
Date of Report:	**Date**
Date of Loss:	**Date**
	Date
Evaluator:	**Dr. J.H. Ennis, Psychiatrist**

SECTION IV

This section is Dr. Ennis' formulation of the data contained in Section I, II, and III.

DIAGNOSIS:

Axis I Pain Disorder Associated with Both Psychological Factors and a General Medical Condition.

Major Depression In Partial Remission.

Axis II Deferred.

Axis III Wide spread soft tissue injuries.

Patient:	**Mr. XXXXX**
Date of Report:	**Date**
Date of Loss:	**Date**
	Date
Evaluator:	**Dr. J.H. Ennis, Psychiatrist**

Axis IV Mr. XXXXX reports stress related to his inability to work. The couple report that they have significant financial pressure.

Axis V Current GAF 50-55 /100.

Patient: **Mr. XXXXX**
Date of Report: **Date**
Date of Loss: **Date**
Date
Evaluator: **Dr. J.H. Ennis, Psychiatrist**

Global Assessment of Functioning (GAF) Scale (DSM - IV Axis V)

Note: The complete GAF scale on page 32 of the DSM - IV and should be consulted for clinical use.

Code	Description of Functioning
91 - 100	Person has **no problems** OR has superior functioning in several areas OR is admired and sought after by others due to positive qualities
81 - 90	Person has **few or no symptoms**. Good functioning in several areas. No more than "everyday" problems or concerns.
71 - 80	Person has symptoms/problems, but they are **temporary, expectable reactions to stressors**. There is no more than slight impairment in any area of psychological functioning.
61 - 70	**Mild symptoms in one area** OR difficulty in one of the following: social, occupational, or school functioning. BUT, the person is generally functioning pretty well and has some meaningful interpersonal relationships.
51 - 60	**Moderate symptoms** OR moderate difficulty in one of the following: social, occupational, or school functioning.
41 - 50	**Serious symptoms** OR serious impairment in one of the following: social, occupational, or school functioning.
31 - 40	**Some impairment in reality testing** OR impairment in speech and communication OR serious impairment in several of the following: occupational or school functioning, interpersonal relationships, judgment, thinking, or mood.
21 - 30	**Presence of hallucinations or delusions which influence behavior**
11 - 20	There is **some danger of harm to self or others**

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CONCLUSION:

Mr. XXXXX is a 52-year-old man who was both physically and psychologically well prior to two accidents. The first accident occurred on date resulting in the onset of the onset of axial spine pain and right arm, shoulder and hand pain. The second accident occurred on date, right knee pain and exacerbation of previous injuries.. However, his physical injuries have not been found to explain his level of pain or disability.

Psychometric testing does not reflect Mr. XXXXX's report of pain and reduced functioning, nor his clinical presentation. The tests indicate that there is no significant psychopathology other than a low clinically significant level of somatization. This finding is not consistent with the patient's clinical presentation. He does not have catastrophic thinking on testing, but on clinical examination, there is clear evidence of such thinking. He described himself as disabled and crippled by his injuries, incapable of doing any physical activity for any length of time. His score on the Oswestry Back Pain Questionnaire does indicate that he perceives himself as crippled as a result of back pain. However, based on his clinical presentation, I did expect a higher score on this test and on the Neck Disability Questionnaire which indicates that he perceives himself as severely disabled as a result of neck pain. His level of function is noted to be reduced, however although his score on the Pain Disability Index is higher than typically seen in patients involved in litigation, it is only slightly elevated. This does not reflect his description of his function. The only tests that are congruent with his clinical presentation are the Orebro, and the Hand and Spine Sorts. The Orebro indicates that there is a very high risk of chronic disability and a low likelihood of return to work. On the Sorts, Mr. XXXXX perceives himself as being below a sedentary level of work capacity. All test results should be considered with some caution given that they were not in Mr. XXXXX's first language. The test questions had to be translated to him.

On psychometric testing Mr. XXXXX does perceive himself as crippled as a result of back pain and severely impaired as a result of neck pain. His Orebro score is above 130 indicating high likelihood of chronic disablement and low likelihood of return to work. Hand sort and Spinal sort indicate that he perceives his capacity as less than sedentary. Of interest, scores on the Pain Catastrophizing Scale are below clinical significance which is not consistent with his clinical presentation. It is possible that because English is his second language the patient may have not understood the questions although they were translated for him. Regardless, this patient's clinical presentation is consistent with a *pain disorder associated with both psychological factors and a general medical condition.*

There is also some evidence of symptom exaggeration. The one test of malingering was negative. This increases the likelihood that these behaviours are unconscious rather than feigned.

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Criteria for Pain Disorder

A. Pain in one or more anatomical sites is the predominant focus of the clinical presentation and is of sufficient severity to warrant clinical attention.

B. The pain causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. Psychological factors are judged to have an important role in the onset, severity, exacerbation, or maintenance of the pain.

D. The symptom or deficit is not intentionally produced or feigned (as in Factitious Disorder or Malingering).

E. The pain is not better accounted for by a Mood, Anxiety, or Psychotic Disorder and does not meet criteria for Dyspareunia.

Code as follows:
307.80 Pain Disorder Associated with Psychological Factors: psychological factors are judged to have the major role in the onset, severity, exacerbation, or maintenance of the pain. (If a general medial condition is present, it does not have a major role in the onset, severity, exacerbation, or maintenance of the pain.) This type of Pain Disorder is not diagnosed if criteria are also met for Somatization Disorder.

Specify if:
Acute: duration of less than 6 months
Chronic: duration of 6 months or longer

307.89 Pain Disorder Associated with Both Psychological Factors and a General Medial Condition: both psychological Factors and a general medial condition are judged to have important roles in the onset, severity exacerbation or maintenance of the pain. The associated general medical condition or anatomical site of the pain (see below) is coded on Axis III.

Specify if:
Acute: duration of less than 6 months
Chronic: duration of 6 months or longer

Note: the following is not considered to e a mental disorder and is included here to facilitate differential diagnosis.

Pain Disorder Associated with a General Medical Condition: a general medial condition has a major role in the onset, severity, exacerbation, or maintenance of the pain. (If psychological factors are present, they are not judged to have a major role in the onset, severity, exacerbation, or maintenance of the pain.) The diagnostic code for the pain is selected based on the associated general medical condition if one has been established or on the anatomical location of the pain if the underlying general medical condition is not yet clearly established - for example, low back (724.2), sciatic (724.3) pelvic (625.9), headache (784.0), facial (784.0), chest (786.5), joint (719.40), bone (733.90), abdominal (789.0), breast (611.71), renal (788.0), ear (388.70), eye (379.91), throat (784.1), tooth (525.9), and urinary (788.0).

There is no evidence that Mr. XXXXX had a somatoform disorder prior to his first accident. Therefore, on the balance of probabilities, the index accidents have made a material contribution to the onset of this disorder.

Comorbid with the pain disorder is evidence of a *major depression*. This has been treated by the primary care physician and currently is in *partial remission*. However the comorbid presence of a mood disorder along with a pain disorder renders the pain disorder more resistant to treatment.

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Dysthymia

A. Depressed mood for most of the day, for more days than not, as indicated either by subjective account or observation by others, for at least 2 years. **Note:** In children and adolescents, mood can be

1. irritable and duration must be at least 1 year.

B. Presence, while depressed, of two (or more) of the following:

(1) poor appetite or overeating
(2) Insomnia or Hypersomnia
(3) low energy or fatigue
(4) low self-esteem
(5) poor concentration or difficulty making decisions
(6) feelings of hopelessness

C. During the 2-year period (1 year for children or adolescents) of the disturbance, the person has never been without the symptoms in Criteria A and B for more than 2 months at a time.

D. No Major Depressive Episode has been present during the first 2 years of the disturbance (1 year for children and adolescents); i.e., the disturbance is not better accounted for by chronic Major Depressive Disorder, or Major Depressive Disorder, In Partial Remission.
Note: There may have been a previous Major Depressive Episode provided there was a full remission (no significant signs or symptoms for 2 months) before development of the Dysthymic Disorder. In addition, after the initial 2 years (1 year in children or adolescents) of Dysthymic Disorder, there may be superimposed episodes of Major Depressive Disorder, in which case both diagnoses may be given when the criteria are met for a Major Depressive Episode.

E. There has never been a Manic Episode, a Mixed Episode, or a Hypomanic Episode, and criteria have never been met for Cyclothymic Disorder.

F. The disturbance does not occur exclusively during the course of a chronic Psychotic Disorder, such as Schizophrenia or Delusional Disorder.

G. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).

H. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:

Early Onset: if onset is before age 21 years
Late Onset: if onset is age 21 years or older

Specify (for most recent 2 years of Dysthymic Disorder):

With Atypical Features

There is no evidence that Mr. XXXXX had *dysthymia* prior to the index accident. Therefore, on the balance of probabilities these accidents have made a material contribution to the onset of this disorder.

In regards to the assessment questions:

1. What are the results of my examination of the Mr. XXXXX?

As described above.

2. What is my opinion in regards to diagnosis?

Axis I	Pain Disorder Associated with Both Psychological Factors and a General Medical Condition.
	Major Depression In Partial Remission.
Axis II	Deferred.
Axis III	Wide spread soft tissue injuries.
Axis IV	Mr. XXXXX reports stress related to his inability to work. The couple report that they have significant financial pressure.
Axis V	Current GAF 50-55 /100.

3. What, if any, effect have the injuries suffered in this motor vehicle accident had on Mr. XXXXX's ability to function in the workplace and household?

Mr. XXXXX presents with a *pain disorder associated with both psychological factors and a general medical condition and a major depression.* The comorbidity of these disorders render this patient disabled. He has a self perception of disability and pain. The end result is that he is avoidant of physical activity. To date he has been unresponsive to typical rehabilitation. Unfortunately, the presence of this somatoform disorder was not identified earlier in the course of treatment. The end result is that Mr. XXXXX has not received optimal treatment for his pain disorder. Now, the pain disorder will be relatively resistant to optimal treatment even if it is provided.

As I have stated previously, the accident made a material contribution to the onset of the *pain disorder associated with both psychological factors and a general medical condition and a major depression.*

4. What, if any, contribution did the motor vehicle accident make toward Mr. XXXXX's present condition?

As stated above, the accident made a material contribution to the onset of the *pain disorder associated with both psychological factors and a general medical condition and a major depression.*

5. What is my opinion in regards to prognosis?

Prognosis is discussed in regards to symptoms and function. In regards to improvement in symptoms, the prognosis is poor. Given the length of time this patient has been symptomatic along with the resistance of the symptoms to treatment support the finding of a poor prognosis.

In regards to function, there has been no appreciable improvement in function over the course of time. In fact, the patient's level of function has deteriorated over the course of time. Given the length of time that Mr. XXXXX has been impaired in regards to function, and the fact that treatment has not affected function indicates that the prognosis in regards to function is poor.

6. Are there any treatment recommendations?

Time was spent with the patient discussing his medications. In my opinion he should not be using Tylenol Number 3 for the purpose of sleep induction.

Mr. XXXXX could benefit from involvement in a behaviourally oriented pain program. Although this treatment has been delayed such that it is less likely that it will have a significant impact on his function, it is still the only treatment that is likely to affect any change. However, Mr. XXXXX has limited command of English and multidisciplinary pain programs typically are conducted in English. However, a one to one pain program could be designed by a *bone fide* multidisciplinary pain program which could utilize the assistance of a translator. It is the only method of treatment that might have an impact on the patient's illness

and pain behaviour. In addition, the family requires therapeutic input. The wife has now become over involved and is infantalizing the husband. It appears that the daughter is now starting to take on responsibility for the father's care which is not in her best interest.

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OPINION OF THE EXAMINER:

The opinions expressed in this report are based upon the examination(s), interviews, records and/or reports described above. They are based upon the subjective complaints and history provided to the examiner, the medical records and tests provided and the physical findings. It is assumed that the material provided is correct. The author reserves the right to alter an expressed opinion, to modify, and/or amend this report should further information come to light which would warrant reconsideration of our opinion. The opinions expressed in this report have been rendered independent of the requesting party and are based upon our professional assessment. This report is not to be copied, distributed or used by other than the requesting party without the consent of the author.

J.H. Ennis, MSW MD FRCP [C]
Evaluating Psychiatrist

JHE:sac
date