

## **Fibromyalgia, Chronic Pain Syndrome and Chronic Fatigue Syndrome**

### **1.0 INTRODUCTION AND PURPOSE**

**It is important to emphasize the following:**

**Please refer to Policy Guideline 04195-CPP-03, Medical Determination of Disability under the CPP.**

- This tool cannot be used as procedures or “rules”; rather, it is a set of criteria against which the facts of each case should be assessed.
- The working tool must always be applied in relation to “the person in respect of whom the determination” is being made. This means that the document must be considered in each case and applied against all particular circumstances of the individual’s situation including the nature and severity of the disease.
- The two criteria “severe” and “prolonged” must be considered in the context of the CPP legislation and the definition provided in the above-mentioned Policy Guideline.

The purpose of this working tool is to:

- review the definition of fibromyalgia, chronic pain syndrome and chronic fatigue syndrome by providing some diagnostic characteristics and criteria to establish or confirm the condition;
- examine principles and excerpts of relevant Pension Appeals Board leading decisions in the area of fibromyalgia, chronic pain syndrome and chronic fatigue syndrome; and
- provide elements to be considered in such cases for the purposes of CPP Disability, in conjunction with Policy Directive 01197-CPP-01, Bill C-S7, Disability Protection for Late Applicants and Policy Guideline 04195-CPP-03, Medical Determination of Disability under the CPP.

### **2.0 BACKGROUND**

In the past few years, many cases of claimed disability have been attributable to new medical conditions which have made CPP disability determination difficult. Among those medical conditions, are fibromyalgia, chronic pain syndrome and chronic fatigue syndrome. This document will assist CPP Disability administrators in understanding these medical conditions and their characteristics. Relevant Pension Appeals Board leading decisions will also be reviewed to outline the principles they contain in addition to elements that must be considered to determine CPP disability.

This document will assist administrators to achieve a more consistent interpretation and application of the CPP legislation and its regulations. It should be noted that an examination of the merits of individual cases is also an important consideration.

### **3.0 CRITERIA AND DIAGNOSTIC CHARACTERISTICS** **FIBROMYALGLA**

Fibromyalgia is a syndrome characterized by diffuse musculoskeletal pain and multiple tender points in specific locations. Over eighty percent of patients are women, and the peak age is 30-50 years. The diagnosis is made on clinical grounds - there are presently no medical tests available such as diagnostic imaging or laboratory tests.

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*Clear criteria for the diagnosis of fibromyalgia have been established by the American College of Rheumatology (1990) and they include. widespread pain for at least three months located bilaterally above and below the waist including the axial skeleton, and at least eleven of eighteen specified tender points.*

*Characteristic associated symptoms include nonrestorative sleep, irritable bowel syndrome, fatigue, stiffness. mood disorders and headache. Other less common symptoms include paresthesia and peripheral vasomotor complaints (resembling Raynaud's phenomenon).*

There are no significant clinical differences in patients considered to have primary versus secondary fibromyalgia (a primary condition is the first and foremost to which others may be secondary or occur as complications). The issue of causality between a specific illness or trauma and secondary fibromyalgia is not clear. There appears to be considerable overlap between the clinical presentation/symptoms of persons with Chronic Fatigue Syndrome and Fibromyalgia.

Myofascial pain syndrome has similarities to fibromyalgia but it is distinguished by localised rather than diffuse pain, trigger points associated with referred pain at other locations, limited associated symptoms and better response to local therapy.

### **CHRONIC PAIN SYNDROME**

Chronic pain syndrome is a pain perception and a pain behaviour disorder with a potential for major psychosocial consequences. Chronic Pain Syndrome is not a psychiatric disorder, nor should it be confused with psychogenic pain.

*The syndrome has to be considered whenever pain lasts longer or is greater than expected/or a given illness or injury. Chronic pain syndrome is not symptomatic of an underlying acute somatic condition nor of a disease with organ system pathology but rather an illness of the whole person. The pain-related behaviour eventually is inconsistent with any underlying noxious stimulus. However, a medical disease/pathology must be ruled out as a cause of pain. Over time, there is a deterioration of coping mechanisms of the individual and under such circumstances, limitations of functional capacity are apt to develop. Among the consequences, despair, alienation from family and society, job loss, isolation, invalidism and suicidal thoughts, may be found.*

According to the American Medical Association (see Guides to the Evaluation of Permanent Impairment, 4th Edition, page 308), the presence of two or more of the following characteristics should be considered to establish a presumptive diagnosis of chronic pain syndrome: the Eight D's of chronic pain are.. .Duration, Dramatization, Diagnostic Dilemma, Drugs, Dependence, Depression, Disuse and Dysfunction.

Chronic pain syndrome has become a major public health problem that results in significant personal suffering. The maladaptive behaviour may also cause medical and socio-economic consequences disproportionate to any somatic components of the illness. Usually, there is no direct correlation between objective impairment and the person's claim of disability.

### **CHRONIC FATIGUE SYNDROME**

This is not a new type of syndrome. It has been labeled in the past as neurasthenia, myalgic

encephalomyelitis, chronic Epstein-Barr virus infection.

Chronic fatigue syndrome is incapacitating fatigue of uncertain etiology of at least six months duration. The U.S. Centre for Disease Control and Prevention has developed a core definition based predominantly on the presence of symptoms and the exclusion of other illnesses.

The patients are twice as likely to be women as men and are generally 25 to 45 years old. Many patients with chronic fatigue syndrome have presented symptoms very similar to those of fibromyalgia and a large proportion are found to fulfill the criteria of fibromyalgia.

### **Case Definition Criteria**

#### **Major criteria**

- Incapacitating exhaustion or fatigue of at least 6 months duration with >50% reduction in average daily activity level
- Exclusion of medical and psychiatric causes of the fatigue

#### **Minor criteria**

- mild fever or chills
- Sore throat
- Painful cervical or axillary lymph nodes
- Unexplained generalized muscle weakness
- Muscle discomfort or myalgia
- Prolonged (>24 hrs) generalized fatigue after exercise that would have been easily tolerated in pre-morbid state
- Generalized headaches of new onset
- Migratory arthralgia without joint swelling or redness
- Neuropsychological complaints (one or more of photophobia, transient visual scotoma, forgetfulness,
- Sleep disturbance (hypersomnia or insomnia)
- Onset of symptoms develops acutely (a few hours to a few days)

#### **Physical signs**

- Low grade fever
- Nonexudate pharyngitis
- Palpable or tender anterior or posterior cervical or axillary lymph nodes

*A diagnosis of chronic fatigue requires that*

- *both major criteria be met **and**;*
- *either 8 of 11 minor criteria*
- *or 6 of 11 minor criteria and 2 or 3 physical signs be met.*

## **4.0 ELEMENTS THAT MUST BE CONSIDERED TO DETERMINE CPP DISABILITY ELIGIBILITY**

### **4.1 Introduction**

The diagnosis of the claimant's disease or condition is important as an element to be considered when one determines eligibility for the CPP disability. However, the diagnosis

should not become the primary and only focus of such an assessment. It is necessary to establish as much as possible just how and to what extent the nature and severity of the disease has impacted or will impact upon the individual: has it produced a CPP disability which can be considered to be both “severe” and “prolonged”?

In the course of evaluating the submitted documentation, serious doubts or concerns may arise with respect to the correctness or validity of the information or statements. Whenever such concerns arise it may be found necessary, in the case of important and pertinent information, to obtain additional evidence to refute, counter or clarify the points in question. Such contentious issues may also arise when there is conflicting or contradictory evidence from various sources. This may necessitate development and possibly, an independent medical consultation.

There are a number of elements to consider in determining whether or not the applicant’s medical condition meets the necessary legislative requirements of “severe and prolonged” (ref. CPP para. 42(2)(a)). In such cases of fibromyalgia, chronic pain syndrome and chronic fatigue syndrome, consideration may be given to the following:

- (4.2) Documentation furnished by the treating physician (family practitioner);
- (4.3) Documentation provided by a specialist or health professional equivalent;
- (4.4) Other information gleaned from the file addressing the applicant’s capacity for work;
- (4.5) whether or not the applicant has satisfied the onus in order to qualify.

Prior to making a decision as to CPP disability, all of these elements (4.2, 4.3, 4.4 and 4.5) should be obtained and considered, if warranted.

#### **4.2 Documentation from family or treating physician**

Medical reports from the treating physician can provide important documentation when one adjudicates a CPP disability claim for benefits. A comprehensive report must contain diagnosis, relevant, significant medical history, any hospitalization, clinical findings, physical findings, functional limitations, outcome of consultations or result of investigations, medication, treatment and response and finally, prognosis. Contrary views on file, based on objective facts, should be investigated if deemed important and pertinent in determining CPP disability eligibility.

Some questions to consider:

- Q.** Does the medical report support the criteria for establishing the diagnosis of fibromyalgia, chronic pain syndrome and chronic fatigue syndrome?
- Q.** Does the evidence in the family or treating physician’s report substantiate the severity of the condition within the meaning of CPP legislation?
- Q.** Is there a contrary view on file from another physician or health professional?
- Q.** Has the client complied with recommended treatment? What was the result of that treatment? Is the client’s condition still preventing him/her from working despite the treatment he/she is receiving?

#### **4.3 Specialist and Health Care Professional**

If a physician holding a fellowship from the Royal College of Physicians and Surgeons of Canada substantiates the applicant cannot work and is unlikely to work in the foreseeable future, and that opinion is given with regard to his/her particular area of expertise, then the opinion must be given more weight and consideration than that of a specialist or physician without expertise in that particular area. For example, a FRCP (Fellow, Royal College of Physicians) rheumatologist says a fibromyalgia patient is unable to work; a FRCS (Fellow, Royal College of Surgeons) general

surgeon says a chronic fatigue patient cannot work - the former meets the criterion, the latter does not, since although he/she is a specialist, he/she is commenting outside the range of his/her specialty.

**OR**

Reports from other health professionals may provide significant information and possibly evidence of equivalent quality or value. That evidence may indicate whether a person can or cannot work and is unlikely to work in the foreseeable future. This evidence could be in the form of:

- a comprehensive report from a neuropsychologist
- a comprehensive report from a qualified professional who routinely performs Functional Capacity Evaluations showing the person is unable to be competitively employed; a Functional Capacity Evaluation can provide an important objective evaluation in assessing physical (and possibly psychological) capacity for work.
- a comprehensive report from a clinical psychologist with a Ph.D. in psychology that concludes the person is unable to work and unlikely to work in the foreseeable future based upon his/her mental functional capacity
- a comprehensive report from an occupational therapist with appropriate credentials that concludes the person is unable to work and unlikely to work in the foreseeable future

Some questions to consider:

- Q.** Is there a physiatrist/rheumatologist report to eliminate possible organic sources of the problem?
- Q.** Is there a psychiatrist/psychologist report to eliminate possible psychiatric causes for the problem?
- Q.** Are the conclusions drawn by physicians, specialists or health professionals based strictly on objective, medical or functional findings?
- Q.** Has the Functional Capacity Evaluation ever been performed for this client? If one is not available, it can be requested by CPP administrators, as required.

**4.4 Other information indicating capacity to work**

Is there other evidence on file in a medical or non-medical report that indicates the capacity - real,

possible, or probable - of gainful employment?

Some questions to consider:

- Q.** Does the client have any difficulties/functional limitations with regards to his/her activities of daily living (i.e. self-care, household chores, sleeping, etc.)
- Q.** Is the client involved in activities (social, volunteer, recreational, remunerative, etc.) that would indicate a capacity for some type of work?
- Q.** Did the client apply for regular Employment Insurance?
- Q.** Was the client laid-off from work?
- Q.** What were the reasons for work stoppage?
- Q.** Has the client attended vocational rehabilitation, recent academic upgrading or skills training?

**5.0 IMPORTANT PRINCIPLES DRAWN FROM PAB DECISIONS**

CPP disability determination in individuals suffering from fibromyalgia, chronic pain syndrome or chronic fatigue syndrome may justify pension entitlement; however, there is a heavy onus on the applicant to show that the condition prevents him/her from working because of a disability, physical or mental, which is both severe and prolonged.

In the absence of objective clinical findings, the credibility of the applicant can influence the

outcome of a case; when the applicant appears sincere and diligent in his/her efforts at treatment, his/her credibility is thereby enhanced.

Where the evidence does not establish that the applicant suffers from a syndrome but is at risk of developing them, the disability cannot be said to be severe for the purposes of CPP Disability.

It must be established that the medical condition is so debilitating that it results in a severe disability. To do so the applicant must provide evidence respecting his/her efforts to cope with the problem and to receive treatment for same. Subjective evidence of the problem and its debilitating nature is essential and must be weighed in each case. Further, evidence from a psychiatrist\psychologist\physiatrist\rheumatologist would be helpful in most cases.

## 6.0 EXCERPTS OF PAB DECISIONS

There have been numerous PAB decisions that can assist CPP administrators in determining disability eligibility. They include:

***MNH&W vs. Reichel*** - November 1991 –Leading Division. Pension denied

The PAB: “This brings us to the type of evidence which should be presented to support a conclusion that chronic pain syndrome is so debilitating as to result in a severe disability. By its very nature, there can be no objective evidence as the pain being described by the patient is inconsistent with the clinical findings. Psychiatric evidence may not be required in all cases, but such evidence would be viewed as helpful for most. Clearly the evidence of an applicant, particularly respecting his or her efforts to cope with the pain and to receive treatment is imperative.

In this case we conclude that the Respondent is not disabled within the meaning of the Act. The same doctor who diagnosed chronic pain syndrome described Mr. Reichel’s condition as unchanged from the time he suggested light work, as noted something which is not contra indicated for chronic pain syndrome. Mr. Reichel’s efforts at ‘light work’ could not be described as such. He is not motivated to perform work at lower pay than his prior employment but, as has often been noted, the payment is not of importance under the Plan as long as the criterion of substantially gainful is met.”

***MNH&W v. Densmore*** - April 1993 -Leading Decision. Pension granted

The PAB: “The issue is difficult because its resolution depends upon the view which the Board ultimately takes of the genuineness of what are strictly subjective symptoms. In effect, the judgment call, made generally without the assistance of objective clinical signs, will be one of credibility on a case by case basis, as to the severity of the pain complained of. It is the Board’s view, often expressed in the cases, that it is not sufficient for chronic pain syndrome to be found to exist. The pain must be such as to prevent the sufferer from regularly pursuing a substantial gainful occupation. We caution also that it is incumbent upon the person who applied for benefits, to show that treatment was sought and efforts were made to cope with the pain. As a result, it will be desirable, although by no means essential in all cases, for an applicant, and helpful to the Board that evidence of a psychiatric or psychological nature be adduced from medical practitioners who by virtue of their experience and general expertise in this difficult area of medicine are able to assist the Board.”

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**Burns v. MNH & W** - October 1993 - Pension denied

The PAB: “This Board has held that chronic pain syndrome under certain circumstances can justify pension entitlement. It does however involve a very heavy onus on a pension applicant to establish that entitlement.

**Johnson v. ME&I** - June 1994 – Pension denied

The PAB: “However, we agree with the Minister’s submission that the evidence before us does not establish on balance that Mr. Johnson does presently suffer from chronic pain syndrome and chronic pain personality compounding his physical disability and, as a result, his incapacity to retrain. He may well reach this threshold soon, but we cannot conclude that he has. The best that can be said in this regard is that he is at risk of becoming so, as stated in the medical reports. That being so, his disability cannot be said to be severe within the meaning of section 42(2)(a) of the Act.”

**Bianco vs. MEI** - May 1996 – Pension granted

The PAB: “Since 1990, he has been tested, examined and treated by innumerable doctors, general practitioners and specialists, attended physiotherapy, attended a pain clinic. He had bone scan tests, bone densitometry, impedance plethysmography, thermography, CT scan, all neurological and radiological tests and exams, and has been prescribed various medications, none of which appear to have improved his condition to any degree.

In August, 1994 (and confirmed in May, 1996), a general practitioner, but who runs a specialized pain clinic, after examinations of the medical records and some actual clinical tests, concluded that Appellant suffers from severe chronic pain dysfunction (and syndrome) with secondary depression, and quite possibly reflex sympathetic dystrophy.

I am satisfied, on all of the evidence and *viva voce* testimony, that Appellant suffers, of long duration, as diagnosed above. There is no suggestion that he is malingering, but he, for whatever causes, now finds himself in a chronic condition which renders him completely dysfunctional and unable to carry on any substantially gainful employment. I conclude that he has satisfied the rather heavy onus imposed upon him, imposed by the jurisprudence of the Board in prior cases, in dealing with cases of chronic pain syndrome. (See *Burns vs. Minister of National Health and Welfare*, **CCH Canadian Employment Benefits and Pension Guide Reports**, #8522, pp. 5992-5993; *Johnson vs. Minister of Employment and Immigration*, *ibid.*, #8563, pp. 6054-6056; and *Minister of National Health and Welfare vs. Densmore*, *ibid.*, #8508, pp. 597 1-5973.)”

**Lethby vs. MEI** - May 1996 – Leading Decision. Pension granted

The PAB: “She has seen and been examined by a plethora of specialists in all fields, and is constantly being seen by her family physician. In order to rule out purely organic causes of her chronic fatigue symptoms, she was examined by a rheumatologist (Dr. Dickson), who ruled out other clinical illnesses and confirmed the chronic fatigue syndrome. Practically the same results were determined by a neurologist/internist (Dr. Stoltz), who found her affected by a “gradual onset of overwhelming fatigue over the past seven years” which, in this doctor’s opinion, was not secondary to the 1992 stroke (see above). This doctor opined that Appellant was “disabled by her fatigue.” Appellant had seen a psychiatrist in 1993, who diagnosed her to, be suffering from a chronic depressive neurosis. But that coupled with her symptoms overall, causes her, in this Board’s opinion, to be completely and prolongedly disabled. Over the past

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seven years, Appellant has been prescribed a multitude of anti-depressant medications. None have improved her extreme tiredness, or they caused her so much side effect stress, they had to be stopped.

There is no suggestion in any of the reports, examinations, or other evidence before this Board that the Appellant is malingering, or exaggerating in any way her problems and symptoms, or is anything other than sincere and diligent in her efforts at therapy and rehabilitation.

In conclusion then as stated the Board is satisfied that Appellant has met the onus upon her and she is in fact, within the criteria as set out above, totally disabled.”

**Card vs. MHRD** - July 1996 – Leading Decision. Pension denied

The PAB: “Counsel for the Appellant submitted that fibromyalgia or chronic pain syndrome had been established on a balance of probabilities. In *Minister of National Health and Welfare vs. Orville R. Menard, CCH Canadian Employment Benefits and Pension Guild Reports, Transfer Binder 1968-1 985, No. 8805, pp. 6468-6470*, the then Chairman, writing for the Board, said this: Functional overlay, diseases of psychogenic origin and hysterical reactions do not in themselves constitute a disability under the Canada Pension Plan, unless they are established, by proper psychiatric evaluation, to be so severe as to prevent any employment and to be of indefinite duration.

This is, as a general rule, as valid and important today as when stated, What is there of “proper psychiatrist evaluation” or psychiatric or psychological or physiatriac” evaluation in this appeal in which fibromyalgia and chronic pain syndrome were, late in the day, relied on? Nothing in the final analysis. There is but the vaguest offhand suggestion and briefest offhand speculation of a general practitioner and specialists in non-psychiatric fields, in entirely passing and incidental fashion and without more.

Neither fibromyalgia nor chronic pain syndrome is a significant basis, if a basis at all, for a finding of disability within the meaning of the Act.

There is, on the evidence before me, no diagnosis of fibromyalgia by any specialist or other medical person. There is no indication in any medical report of the conducting of relevant tests. There is no diagnosis of chronic pain syndrome. Even if this hurdle be assumed met and fibromyalgia or chronic pain syndrome, in some degree, be found established on medical evidence, the disabling nature and extent of them remains to be determined. They may or may not be disabling within the meaning of the Act.

The Appellant has not established, as she must do to have success on this appeal, on a preponderance of evidence, that she is disabled within the meaning of the Act. This is so whether disability be looked at in terms of actual loss of function, functional pain or perception of pain or any combination of the three. This is, however, particularly so in the area of fibromyalgia and chronic pain syndrome, which were in argument emphasized by the Appellant, for the reasons stated above.”

**MHRD vs. Warrick** - August 1996 - Leading Decision. Pension granted

The PAB: “Credibility is at the heart of this appeal.

There are three important considerations on the road to a finding of disability within the meaning of the Act based on fibromyalgia or chronic pain syndrome or either of them, somewhat combined with functional pain as a contributor. The Respondent relies, among other things, on fibromyalgia as a basis for disability. These are the three important considerations:

- 1) The high quality of the Respondent's evidence and its acceptance as referred to elsewhere.
- 2) The expert medical evidence of fibromyalgia or chronic pain syndrome tending to meeting *Densmore* as later mentioned.
- 3) The bit of "comfort" to the Respondent and her claim found in the evidence of the Minister's medical report expert, Dr. O'Brien, as dealt with elsewhere.

While *Densmore* speaks in the context of chronic pain syndrome, perhaps it has something to say about disability within the meaning of the Act based, in whole or in part, on fibromyalgia, stress, stress response, post traumatic stress, "post traumatic stress syndrome," "chronic fatigue," "environmental hypersensitivities," and the like. The difference between some of these expressions or "labels" may be more apparent than real. Medical people only are entitled to speak authoritatively in that area. However that may be, little can be said against some special care and caution in dealing with this genus of complaint as a basis for disability within the meaning of the Act. That is my approach on this appeal. The Appellant does not deny that the Respondent suffers pain, or at least, some pain. In result, in my view, the tests set out in *Densmore* and the test of care and caution have been met by the Respondent. I do not suggest that they have been met in ideal fashion for all situations but in a marginal fashion sufficient for present purposes."

***Fullarton: vs. MHRD*** - September 1996-Leading Decision. Pension denied

The PAB: "Dr. Kanjilal, for the Respondent, testified that to arrive at a diagnosis of CFS, the process is one of elimination. You first must eliminate possible organic sources of the problem, then you move on and examine psychiatric problems, if any. He testified CFS is not a specialty in medicine and it consists of a number of symptoms which objectively exist. He went on to say that Dr. Grant is a well-known Rheumatologist and, because the Appellant had no confidence in Dr. Henderson, it was suggested she see Dr. Grant. The object was to eliminate any organic problem; a psychiatrist could then have been consulted.

Dr. Kanjilal's evidence, in my view, made good sense, particularly when examining some literature filed by the Appellant - a study entitled *The Chronic Fatigue Syndrome: A Comprehensive Approach to Its Definition and Study* - states that: Diagnosis of the chronic fatigue syndrome can be made only after alternative medical and psychiatric causes of chronic fatiguing illness have been excluded.

The Appellant testified, when asked if she had ever seen a psychiatrist or psychologist, that this was not necessary.

The difficulty with the Appellant's position is that all alternative explanations have not as yet been examined. As an example, cognitive problems are repeatedly mentioned in the doctors' reports submitted by the Appellant, yet no recommendation has been made by the practitioners to have these examined by either of these specialists.

The Appellant appeared before us with a well organized brief. She has done a tremendous amount of reading and organizing of material. She is bright, extremely articulate and presented

her case calmly.

I find it extremely difficult to believe she has a cognitive deficit or is cognitively dysfunctional, as she concludes.

In summary, there is insufficient evidence to support a claim that the Appellant is disabled within the meaning of the Canada Pension Plan definition.”

**Carbone vs. MHRD** - March 1997 - Pension granted

The PAB: “In the case of *Minister of National Health and Welfare vs. Densmore*. CCH *Canadian Employment Benefits and Pension Guide Report*. No. 8508, pp. 5971-5973, the Board held that in a chronic pain syndrome situation, the pain must be such as to prevent the sufferer from regularly pursuing a substantially gainful occupation. It further held that the individual must show that treatment was sought and efforts were made to cope with the pain. Also that it would be desirable that evidence of a psychiatric, or psychological, or psychiatric nature be adduced.

In regard to the first point, a majority of the medical professional who examined the Appellant and supplied reports were of the opinion that the Appellant would never be capable of future gainful employment. One member was of the opinion that he could eventually return “to full activities.” Another member was of the opinion that he would “have to be retrained for light part-time duties” Two did not express an opinion.

As to the second point, there is no question but that the Appellant sought treatment and that efforts were made to cope with the pain. The evidence shows that he attended a pain clinic and received several injections in an effort to relieve the pain.

As to the third point, it is unfortunate that the Board did not receive the full psychiatric report of Dr. Arbitman, but the Appellant did testify that he was examined by the doctor and Dr. Sokol referred to part of the report. Several of the medical reports referred to the Appellant’s depression and to the fact that he is taking antidepressant medication.

On the whole of the evidence and after seeing and hearing the Appellant in the Courtroom and after being informed of his excellent work record prior to his accident, I am satisfied that the Appellant has proven on a balance of probabilities that he has a disability...”

## 7.0 REFERENCES

Subsection 42(2) of Canada Pension Plan  
Subsections 68 (1) and (2) of the Canada Pension Plan Regulations  
Policy Directive 01/97-CPP-01, Bill C-57,  
Disability Protection for Late Applicants Policy Guideline C4/95-CPP-03,  
Medical Determination of Disability under the Canada Pension Plan

**8.0 CONTACT:** If further information is required about this document, please contact:  
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