

Highlights

ETE
1998
Summer

Focus on Chronic Pain

We are pleased to bring you our summer edition of our national newsletter, Highlights. This issue contains some interesting reading beginning with our lead article "The Denial of Chronic Pain" by Dr. Robert Teasell. Dr. Teasell has done his homework quoting from numerous studies that point to the medical causes of pain. These are often ignored by governments which are focusing on cutting costs rather than the reality of people suffering from chronic pain.

We then track the policy and practices of the Provincial and Territorial WCB's in their treatment of chronic pain. Clearly, they are more interested in cutting costs rather than providing appropriate support and treatment.

The real story is hidden behind these WCB policies. It is the story of real people suffering in pain every day, dealing with depression and hardships that effect the whole family.

Also inside is information about our National Speakers Bureau project and letters to the editor - one of which announces a new website and chatline; injuredworkers online. Talking to each other and sharing our experiences helps to build our knowledge and confidence which makes dealing with the system that much easier.

We encourage you to plug in. Tune in to injuredworker online, invite one of our speakers out to your next meeting, share your story with others or drop us a line to be included in the next newsletter. And as Jeff Collette says in his letter after winning his case, "Now focusing on justice for others."



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CIWA/ACVAMT Projects

For more information on any of our projects, give us call at 807-345-3429

TOGETHER WE CAN WIN

Our video and workbook are receiving a very positive response. It is only 8 months since the national launch of these resources and we have just completed the third printing.

As well, the Canadian Labour Congress invited us to show this video at the opening session of their National Health & Safety Conference on June 21st in Toronto.

Give us a call to get your own copy.

STAFF AT THE OFFICE

We regret to announce that Tara Lewis will be leaving us for greener pastures in Nova Scotia by the end of July. She has been such a wonderful, independent, caring, hard-working bonus to our office, that words alone cannot possibly express how sorry we are to see her go. Good Luck !

We have recently hired a summer student under the "Summer Experiences Program" through funding from the Ontario Ministry of Citizenship. This student will update and develop our website over the next 2 months.

Keep your eyes peeled for a new and improved site!

SPEAKERS BUREAU

Returning to Work

We now have 53 trained presenters from local injured workers groups all across the country. They are prepared to come out to any local meeting to give a 15 - 30 minute talk on the experiences of injured and disabled workers. A complete list of these presenters is available from CIWA.

The presentation is accompanied by a series of illustrated overheads, a handout on "How you can help" and a display table of additional information and resource materials.

The response so far has been enthusiastic. Presentations have been made to local union meetings, health and safety committee meetings, the WCB's in Nova Scotia, Saskatchewan & Alberta, the Manitoba Federation of Labour, WCB Committees, Community Meetings and Injured Workers meetings, only to name a few.

This project is a partnership with the Canadian Labour Congress and our local injured workers groups.

Arrange for one of our presenters to deliver a presentation at your next local meeting !

Thanks to the HRDC for supporting this project.

C.I.W.A. Board Members

BC... <i>Vacant</i>	QC... <i>Liane Flibotte</i> , Montreal l'ATTAQ
AB ... <i>Vacant</i>	NF... <i>Phil Brake</i> , Labrador City U.S.W.A.
SK... <i>Robert Lindsay</i> , Regina Saskatchewan Injured Workers Society	NB... <i>Wendy McGee</i> , Saint John St. John Labour Community Services Inc.
MN... <i>Wayne Desiatnyk</i> , Winnipeg Injured Workers of Manitoba	NS... <i>Dave MacKenzie</i> , Westville Pictou County Pictou County Injured Workers Assoc.
ON... <i>Joan Crevar</i> , Hamilton Ontario Network of Injured Workers Groups	PEI... <i>Vacant</i> ADVISORS... <i>Andy King</i> , USWA <i>Orlando Buonastella & Marion Endicott</i> , IWC

Provincial Updates: *Focus on CHRONIC PAIN*

The next issue of the newsletter will focus on ORGANIZING. We welcome your contributions. Please send, fax or e-mail your submissions, letters or comments to us by September 10th, 1998.

The Denial of Chronic Pain

Dr. Robert Teasell

There is a current and disconcerting trend towards dealing with chronic pain and its subsequent disability by denying its reality. The reason for this has been primarily cost containment and cost reduction. The monograph on Back Pain in the Workplace probably best reflected this philosophy wherein pain was defined as activity intolerance and disability as unemployment. Recently Bill 99 in the Ontario legislature has put forward changes in the Workers' Compensation Board's provision which in essence would limit patients' medical and compensation entitlements to anywhere from 6-13 weeks depending upon the nature of their job. Responsibility for rehabilitation and getting the employee back to work would be transferred to the employer.

Undoubtedly, accommodations by employers are essential in enabling injured workers to successfully

return to some form of employment. However, under the new proposal, the employer is only responsible for trying to provide suitable or comparable work and the temptation to deny workers' injuries, particularly in non-union environments, will no doubt be high.

This approach is a radical departure from previous policies. Models of chronic pain management through denial are based on the proposition that chronic pain occurs as a consequence of compensation and inappropriate treatment. Moreover, they emphasize the outmoded concept that soft tissue injuries heal after six weeks and cling to increasingly irrelevant behavioural models of chronic pain.

The irony of developments is that they come at a time when we understand the physiological basis of chronic pain better than ever before. As well, the concepts that chronic pain are largely secondary to compensation or psychological factors have been largely refuted. Scientific evidence of a

physiological causation for ongoing chronic pain is well-recognized and even the biopsychosocial model recognized the importance of organic factors in chronic pain.

Chronic pain disorders generally develop after a repetitive low impact type of trauma or a single high impact trauma. Much of the debate regarding persistent pain revolves around the normal anticipated time for musculoligamentous healing to occur. There has long been misconception that all injuries should heal after six weeks. This rationale is based on a few animal studies and the clinical experience that the majority of injuries do improve within six weeks. However, clinical experience and follow-up studies clearly demonstrate that not all patients necessarily get better and that there is a significant subset who continue to suffer from chronic symptoms. Some become disabled, depending upon both the intensity of pain and psychosocial factors, such as the type of employment they are involved in.

Ironically, in sports medicine it is well recognized many professional and non-professional athletes have longstanding injuries which are soft tissue in nature, which do not get better with time, or which require many months of therapy and abstention from sports. Such injuries have terminated many promising careers. The legislation in Bill 99 for the WCB of Ontario proposes standards for injured workers which could not be met by many professional athletes, despite the fact that they are highly motivated and in top physical shape, have the best medical care and trainers and receive full compensation even when injured. Fortunately, such individuals are not included in this proposed legislation which, if extended to prominent athletes, would result in a public outcry.



The evidence that chronic pain has an organized etiology is growing and has become increasingly compelling. In the area of whiplash injuries, the work of Bogduk and associates in Australia has been particularly interesting in that they have been able to

demonstrate that when local anaesthetics are used to block cervical facets joints a majority of appropriate patients experience reduction in their pain far in excess of that from placebo injections. In addition, they have shown in a controlled trial that percutaneous neurotomies denervating these same facet joints will significantly reduce or eliminate the pain of these individuals for periods in excess of six months. It is interesting that this highly impressive research is largely ignored outside and to some extent within the academic community.

There is also impressive evidence of significant biochemical abnormalities in disorders such as fibromyalgia where three independent studies have demonstrated levels of substance P in the cerebral spinal fluid 2 - 3 times that of normal control. As well, we know that based upon animal data there is significant evidence of neuroplasticity in the spinal cord in response to pain stimuli which could account for the clinical picture of regional pain syndromes. In these conditions neurotransmitters such as substance P have also been implicated. More recently altered regional cerebral blood flow have offered opportunities to actually document a physiological evidence about pain, the scientific evidence does not appear to be reaching legislators or those clinicians who seem determined, based on ideology, to impose draconian alternative paradigms to deal with chronic pain and in particular its associated disability.

To justify such an approach psychosocial factors are often implicated as causative. However, a wave of recent research has demonstrated that psychological factors are more secondary to pain than causative. The high incidence of psychological problems seen in tertiary care clinics reflects tertiary care selection biases and the literature, which largely arises from such clinics, clearly displays this bias. In fact, the problem may be more related to the chronic pain patient's unwillingness to accept (and subsequently adapt to) their pain and its limitation. Psychological difficulties occurring as a consequence of the pain and subsequent disability are often misinterpreted as causative.

Individual coping mechanisms vary but this is true of any medical disorder. Patients with rheumatoid

arthritis can have significant psychological difficulties and it has been suggested that psychological factors contribute to rheumatoid arthritis pain and functional disability, independent of disease activity. Among spinal cord injured patients with pain, over one-third of individuals who stopped working after the spinal cord injury said it was because of their pain and not their paralysis. Interestingly, pain was regarded by these spinal cord injured patients as a significant cause of work disability even when the individual had a more "acceptable" alternative explanation (ie. paralysis) for work disability. It also suggests that in some patients pain is regarded as more disabling than paralysis/paresis.

The controversy about chronic pain and disability is inevitably tied to perceived secondary gain and the availability of compensation. Recent data suggests that compensation is important, particularly in terms of the number of claims but that its importance has been overrated in terms of pain as it accounts for only a small degree of the variance seen, (6% in one meta-analysis). Its effect on claims is gradational, a not unexpected relationship. On the other hand "secondary gain" is a vague term which has never been well explained. Anybody who treats these patients regularly realizes that the concept of secondary gain also has to be coupled with secondary losses and most of these patients continue to have pain despite the fact that secondary losses clearly exceed secondary gains.

It is most disconcerting that the patients who will be affected by changes in legislation are those shown to be at highest risk of disability, namely those in lower socioeconomic groups, in particular those who are poorly educated, who lack transferable skills, are older and more likely to perform heavy or repetitive physical labour. Most of these would be classified as "blue collar" workers or the "working poor". Many are immigrants with limited communication skills and/or working women who appear to be more susceptible to developing conditions such as repetitive strain injury, fibromyalgia and myofascial type pain. Attempts to deal with chronic pain disability as a social problem will serve only to target those individuals who are especially

vulnerable to withdrawal of support. This vulnerability is further enhanced by significant changes in the availability of work for individuals without specific technical skills and a decreased willingness on the part of employers to accommodate or compromise the workplace for injured workers. This is not just true for chronic soft tissue type pain but is also reported in conditions such as rheumatoid arthritis.

Canada is becoming increasingly less sympathetic towards the weak, the poor, the injured and the disadvantaged. The Darwinian mindset sees such individuals as a drain on society and in particular, contrary to the economics of profitable business.

Certainly the cost of disability is an important factor that must be taken into consideration. However, we seem to have crossed a threshold where it is increasingly acceptable to demonstrate a lack of empathy or compassion for anybody who is injured and in particular, those who have chronic pain. Governments not only fail to display compassion for injured workers, but displaying such compassion is seen as weakness for not staying the course of significantly reducing direct costs.

As health care professionals and researchers, we have an obligation to point out to our politicians and society in general that there is a significant human cost to proposed policy changes. Short-changing people when they are most vulnerable is going to markedly increase suffering while at the same time swelling the welfare roles and transferring the problem to other jurisdictions.

Although such measures may well force some individuals to return to work who might not have otherwise done so, the fact is that the vast majority of individuals are likely going to end up without resources at a time when they need them the most. Knowing what we now know about chronic pain, such an approach clearly strains the ethical responsibilities we have for those individuals who are limited by chronic pain in our society.

This report was presented at the hearings on Bill 99 in London, ON.

YUKON

The Yukon has no policy on chronic pain. What they have is a policy that deals with other related conditions that hinder recovery. Conditions that hinder recovery from a work-related disability includes, but are not limited to the following: alcoholism, drug addiction and chronic pain. The Board allows for 6 weeks of treatment.

However, the administration of the WCB is interpreting this policy to apply to workers who are suffering a disability as a result of a work-related injury. The Board makes no distinction between Chronic Pain (organic findings) and Chronic pain Syndrome (non-organic findings) and is very quick with the euphemism -its pain that's limiting your ability not the injury and the WCB doesn't pay for pain.

To take it to the absurd, a burn victim in excruciating pain from the wounds would only be entitled to 6 weeks of benefits, as it is the pain that is stopping him from working, not any functional disability.

I believe that the policy is intended to deal with non-compensable barriers to employment and not conditions arising out of or in the course of employment. I believe in the Yukon, workers are entitled to full total temporary benefits until they are assisted to overcome the physical, social and economic hardships brought on by the disability.

Several of the cases were brought through the appeal process prior and were unsuccessful. I am unaware of the arguments used then, however, we have a good case going before the Appeal Panel in the near future. There are also plans for Policy and Legislative review and we are hoping to have favorable amendments made.

Chronic Pain and Syndrome clients have been dealt with very poorly in the territory. Historically there is very seldom early diagnosis, limited psychological counseling to assist injured workers adjust to the rationalizations that their entire life has been impacted by a workplace injury and the results are

permanent. Pain Clinics are viewed by injured workers as a formality prior to terminating benefits even if the worker is still suffering from the work related disability.

BRITISH COLUMBIA

A Task Force on Pain in The Workplace, financed by WCB and the Insurance Companies, is trying to state that if you are chronically disabled because of pain, that you should be treated as refusing to work; causing your own unemployment and therefore abandoned by the system of insurance, be it through WCB or private companies or CPP. The areas of analysis these people are using to arrive at their conclusions is based on a process developed by Miller, that is over 35 years old AND WHICH HAS BEEN PROVED TO BE INHERENTLY FLAWED, with the results that data gathered using this method is transparently self promoting.

Many Doctors, who are nationally and internationally published, are coming to recognize that those who promote this type of analysis are not keeping abreast of the current medical research and findings. It has, in fact, been published in both medical and psychological journals that they are simply "bankrupt" in their expertise in these matters. It is also clearly stated that there is only one issue at stake when dealing with people who are disabled through pain: MONEY, and how to stop you getting it!

The facts show that between 6% and 10% of people suffering, seriously and continuously, from pain are work disabled. (Disability is defined as "a restriction or lack..... of ability to perform an activity in the manner or within the range considered normal for a human being." World Health Organization)

The difficulties for the sufferers of chronic pain arise from the following. Because there are often no clearly defined reasons for the pain in the form of x-rays (etc), then doctors cannot clearly state why the person is suffering. Doctors, therefore, tend to be

wishy-washy in their statements regarding the level of disability being suffered. Several very serious articles published as recently as 1997 state: that it is poor medical knowledge and practice that is at fault. They seriously suggest that doctors do not know their stuff and fall back on the readings, at the time of their training, often by people such as Miller, who use terms such as psycho-social, psychopathogenic, secondary gain, etc. Basically, these mean that the pain sufferer's disability is "all in his head" and that he is trying to fraudulently get compensation for a minor injury. It might also be suggested that doctors adhering to this medico-legal analysis are in breach of their Hippocratic oath for the following reasons.

Though there are no clearly defined patho-anatomical or patho-physiological explanations in 85% of cases where long term pain is experienced, it is known that many of the cases result from trauma, i.e. an accident of some kind.

It is regularly stated by doctors, apparently incorrectly, as generally being repaired in a very short time. They do not take into consideration, however, work by people such as McNole, which denies this and has proved that "important physical alterations occur that could be the source of chronic pain."

Though it is clearly known that there are a wide array of injuries that do not "heal" in the expected time and actually defy the models being promoted by the insurance companies and WCB in particular, doctors continue to penalize sufferers due to their lack of knowledge and understanding.

Alternative reasons for the long term pain being suffered are promoted by people like Barnsley et al who provides strong evidence of FACET JOINT involvement in neck traumas. Sturzenegger and colleagues found that whiplash patients who still had problems after one week - which they state was indicative of a more severe injury - were significantly related to symptoms at one year (post accident).

P.D.Wall has found that chronic pain can be induced by biochemical abnormalities that can result after

trauma. Mense has recently published an article regarding pain chronicity arising from muscle damage.

And on it goes, providing data and a growing body of evidence that there is a well documented neurophysiological basis for the persistence of pain in so-called "soft tissue injured".

Thomson (1997) states that: "Bankrupt experts operate with the faulty assumption that pain not seen on x-rays or scans, nor cured by surgery, was "non-organic" equaling "psychosomatic" which in many jurisdictions (insurance companies) is non-compensable.

She suggests that doctors, when dealing with such pain, show "a failure to follow carefully drawn dermatomal maps. The problem seems to rest with the cartographers (doctors) NOT the patients."

She refers back to the important work by P.D.Wall who - "outlined the limitations and inherent inaccuracies in current dermatomal maps because DERMATOMAL BOUNDARIES CHANGE MARKEDLY IF THE NERVE (ROOT) STUDIED IS SECTIONED ON THE PERIPHERAL SIDE OF THE DORSAL ROOT GANGLION." These facts may invalidate the use of the Ransford pain drawings which are often used to detect malingerers and people suspected of psychosomatic problems.

This leads us to the concept of secondary gain, which includes the concepts of "rights" and "compensation". This all encompassing and poorly defined concept suggests that those persons bedeviled by their pain will gain economically, physically and emotionally from having an illness and this casts suspicion on the legitimacy of the recipient. Those of us in this condition have no doubt that it affects the quality of treatment we receive and this prospect is supported by Fishbain when he states, "the identification of PRESUMED secondary gain does not necessarily mean that secondary gain had an etiological or reinforcing affect on the chronic pain" an ERROR referred to as "over-inference".

He backs this up by further discussing the REALITY of chronic pain sufferers when he clearly and specifically discusses SECONDARY LOSSES and infers that where these outweigh potential gains, they must be treated with a higher degree of relevance to support the injured party.

Dr. Gary Lea in his paper on Secondary Traumatization, would seem to concur with this line of reasoning, expanding on the process to the extent that people who are suffering from chronic pain are, in fact, made to suffer even more by the organization's supposedly there to relieve their misery.

In conclusion, for those who are still skeptical and too lazy to think of doing their own research, I would refer you to a recent article/editorial by Quinn Hogan which outlines reasons why the old experts have not been successful and how new approaches can.

[This letter is based on published articles by R W Teasell and Harold Marsky and Ellen Thompson.]

Mike Shepherd

ALBERTA

In Alberta, Chronic Pain may be one of the most fought issues at appeals. We do have Policy in place for chronic pain, but having it accepted is very rare. Policy states: "If because of a workplace accident, you injury causes prolonged uncontrolled pain: The Board may compensate a claimant for prolonged and uncontrolled pain.

The Alberta Board offers pain clinics, and some alternative medicines and may pay the worker benefits while the worker is seeking treatment. Workers often spend countless months appealing this issue, and are often told the pain is in their heads. A panel currently is reviewing this policy to modify it or redo it, both entitlement and treatments. In Alberta, there are chronic pain clinics, T.E.N.S. machines, morphine implants and now they are trying to push for brain and back implant.

Most of the treatments are only short term and most often claimants return to medication to control pain and increased spasms. Most injured workers with chronic pain are treated very poorly and told that the pain is all in the head. They usually send workers to a psychologist and have the Board's words come through the Psychologist's mouth. After two or three visits to a psychologist they are cut off.

SASKATCHEWAN

This letter is in regards to chronic pain in the province of SK. The WCB seems to have a hard time accepting chronic pain. The problem with chronic pain is most people and WCB do not understand the effects it has on injured workers. WCB thinks chronic pain is in the injured workers head, or that he or she is faking the disability.

When someone is in severe chronic pain, it is so devastating that the individual has a hard time to function properly. No one's pain is the same, but WCB thinks chronic pain is nothing.

Chronic pain victims are not only disabled, but most chronic pain victims are so devastated trying to cope with it.

Chronic pain is an invisible disability, and most times WCB and family don't understand because they cannot see the disability. This makes it so hard for family members to even understand, therefore causing tremendous stress on families, trying to understand.

WCB in Saskatchewan has gone as far as paying for chronic pain implants, but says it does not recognize chronic pain as a disability. Very easy for someone to say when they haven't experienced it themselves, and have no idea.

Some chronic pain would be like being burnt, or some of the worst migraines, or even feeling of stabbing pain 24 hours around the clock.

We know some people take time off work for a flu, or bad cold or just not feeling well. This isn't even close to comparing with chronic pain.

We have seen and heard of suicides, marriage break-ups, nervous break-downs, etc. with chronic pain

victims. I don't know of anyone who would try this because of the flu or just not feeling well.

We must be sure to make WCB understand. These people deserve benefits the same as anyone else would, as it is a disability. CPP recognizes chronic pain, why won't WCB in SK?

Deep Brain & Back implants in Saskatchewan

In the Province of Saskatchewan, I have met and seen persons who have had back and brain implants for chronic pain. My understanding is these people were told by WCB in SK, that if they didn't have these implants then benefits would be terminated.

I have seen the equipment that was used on a patient that has received 9 back implants, and 4 deep brain implants. Can you imagine this many implants on one person. This individual has a medication expense of \$7,400.00 per month which is covered by SK WCB, at the same time telling the injured worker he is capable of working an 8 hour shift.

The people I have met, have had the wires left inside their head as they cannot be removed, but they were originally told they could be. These people, because of what has been left inside of their brain, are experiencing so many side effects, that they are totally disabled. WCB disagrees with that.

These people's lives have been shattered because of the side effects. They cannot go outside very often, bright lighting affects them, even in an electrical storm - they must stay inside.

Our understanding is these implants were never meant for chronic pain. It was a trial base for Parkinson Disease - not for Chronic Pain. These patients were never ever told it was an experimental procedure.

I have seen the equipment that was used on one patient that states on the back of it that it was banned in the USA in 1982 and is not to be sold in Canada or to any physician.

These individuals that I have met, are experiencing minor strokes, and devastating side effects which has totally disabled these people. I do not know of the exact amount of people that this has been done to, but we knew the numbers are very, very high in SK.

We urge the other Provincial injured workers groups to make sure it is investigated in their own province to be sure it doesn't happen in your own back yard.

We now have lawyers looking into the matter in SK, and are going forward with a class action suit.

Robert Lindsay

MANITOBA

Manitoba has no clear policy on or entitlement for chronic pain. A policy was developed by the WCB in 1990 that would provide some limited coverage for chronic pain. Unfortunately, that policy was never adopted.

ONTARIO

From WCB Policy Report

December 1990 Volume 3
CHANGES TO CHRONIC PAIN
DISABILITY (CPD)

Category 1 Minor Impairment of Total Person (10%)

In this category the Injured worker's daily activity is slightly limited and no apparent difficulties are reported in personal adjustment. There is also some loss in personal or social efficacy and the secondary psychogenic aggravations are caused by the emotional impact of the accident. A mild anxiety reaction is apparent. The display of symptoms indicate a form of restlessness, some degree of

subjective uneasiness and tension caused by anxiety. There are subjective limitations in functioning as a result of the emotional impact of the accident.

The disability, from the psychiatric point of view, is not expected to be permanent.

Category 2

Moderate Impairment of Total Person (15% - 25%)

In this category, the worker is still capable of looking after personal needs in the home environment but, with time, confluence diminishes and the worker becomes more dependent on the members of the family in all activities which take place outside the home. The worker demonstrates a moderate, at times episodic, anxiety state, agitation with excessive fear of re-injury, nurturing strong passive dependency tendencies. The emotional state may be compounded with persistent pain, signs of emotional withdrawal and depressive features loss of appetite, insomnia, chronic fatigue, low noise tolerance, mild psychomotor retardation and definite limitations in social and personal adjustment with the family. At this stage, there is a clear indication of psychological regression.

Category 3

Moderate Impairment of Total Person (30% - 50%)

In this category, the worker displays a severe anxiety state, definite deterioration. In family adjustment, incident breakdown of social integration, and longer episodes of depression. The worker tends to withdraw from the family, develops severe noise intolerance and a significant diminished stress tolerance. A phobic pattern or conversion reaction will surface with some bizarre behavior, a tendency to avoid anxiety-creating situations, with everyday activities restricted to such an extent that the worker may be homebound or even room bound at frequent intervals.

Category 4

Severe Impairment of Total Persons (60% - 80%)

In this category, the worker clearly displays a chronic and severe limitations of adaptation and function in the home and outside environment. The

worker is withdrawn, forgetful, unable to concentrate, and needs continuous emotional support outside environment. The worker is incapable of self care and neglects personal hygiene. There may be an obvious loss of interest in the environment and the worker becomes extremely irritable, showing significant emotional lability, changes of mood and uncontrolled outbursts of temper. The worker may be severely depressed with outstanding features of psychomotor retardation and psychological regression. The worker is usually homebound or even room bound. Because both the CPD and Psychotraumatic rating systems are based on assessing the effect of the impairment on an injured worker, and because the Psychotraumatic system is more detailed and therefore, more precise, the board of directors considered it reasonable to use only that schedule for both CPD and Psychotraumatic conditions, and to rename it: "Psychotraumatic and Behavioral Disorders Rating Schedule". As such, the old Interim CPD rating schedule has been abolished, and **CPD** Fibromyalgia syndrome (recognized as variant of CPD), and **psychotraumatic disabilities** will all be rated under the new schedule:

Level of Total Person Impairment	Degree of Impairment
Category 1.....	10%
Category 2.....	15% - 25%
Category 3.....	30% - 50%
Category 4.....	60% - 80%

The change in the rating schedule is retrospective from March 27, 1986, the effective date of the CPD policy.

QUEBEC

L'indemnisation pour la douleur chronique

Au Québec, l'indemnisation pour la douleur chronique n'existe pas en tant que telle dans le cadre de la Loi sur les accidents du travail et les maladies professionnelles. Toutefois, les victimes d'accidents et de maladies du travail qui souffrent de douleur

chronique peuvent avoir accès à divers traitements dans le cadre de la réadaptation.

Ces personnes peuvent donc, dans la mesure où la CSST accepte de les leur accorder, recevoir des traitements de physiothérapie, d'acupuncture, de massothérapie, de psychothérapie, etc. Également, si la douleur chronique entraîne une lésion d'ordre psychologique, cette dernière peut être indemnisée par la CSST.

Ainsi, même si la douleur chronique n'est pas formellement indemnisée dans le cadre du régime québécois d'indemnisation, elle peut donner ouverture à certains soins ou à la reconnaissance de certaines lésions qui en découlent.

Chronic Pain - Quebec

In Quebec compensation for chronic pain does not exist per se within the scope of the *Act respecting accidents and occupational diseases*. Nevertheless, injured workers suffering from chronic pain may access different treatments as part of their rehabilitation program.

These persons may therefore receive physiotherapy, acupuncture, massotherapy, psychotherapy and other treatments, inasmuch as the CSST agrees to grant them. Also, if chronic pain leads to psychological injury, the latter may be compensated by the CSST.

Therefore, although chronic pain is not officially compensated within the Quebec compensation system, it may lead to some care or the recognition of some injuries stemming therefrom. -Liane Flibotte

NEW BRUNSWICK

Chronic pain is not compensated for in NB. In fact, specific policy is written regarding FIBROMYALGIA (25-041) and MYOFASCIAL PAIN SYNDROME (25-040).

Fibromyalgia syndrome is considered a personal condition, not the result of trauma, and thus, not acceptable by the Workers' Compensation Board.

Myofascial pain syndrome may be initiated by a work injury, thus establishing a relationship between the cause and effect. The Workers' Compensation Board is responsible for the original trauma to the muscle only and has no responsibility for the perpetuating factors which are not related to the accident. However, should the perpetuating factors be caused by a work-related activity, the Board's responsibility continues.

PPI awards do not consider pain an impairment ratings. Since myofascial pain syndrome is defined as a muscular disease which is considered to be completely reversible in the absence of perpetuating factors, along with no demonstrable physical or anatomical lesions, it is not considered for the awarding of a Permanent Physical Impairment Award, or P.P.I., in accordance with s.38.2(8) of the *Workers' Compensation Act*.

WHSCC is presently considering a large number of amendments. A special organization has been adopted to review these proposed amendments.

Stakeholders: labour, employers, injured workers, workers' advocates, employer advocates, etc. have all been invited to respond in writing to any & all the proposals under consideration. WHSCC staff will meet with groups to discuss and clarify any intent or ambiguities that may exist. Groups are invited to make an oral presentation to elaborate upon their written submission. This is, by far, the most elaborate process I have come across when amendments to the OH&S Act, the WCA Act and the WHS&CC Act have been considered. Perhaps the

Commission realizes that the tactics used in the past are not acceptable. It's about time!

The proposed amendments to the three Acts have been classified into the following eight categories:

1. Health & Safety Issues
2. Eligibility Issues

3. Assessments
4. Obligations
5. Third Party Actions
6. Powers of the Commission
7. Board of Directors & Appeals Tribunal
8. Housekeeping

I will briefly note what I believe will have a detrimental effect on injured workers in NB.

WC Act Sec. 41(16)

Worker responsibility not to impede medical treatment

Proposed change expands 41(16) so that when a non-injury related factor impedes recovery, the Commission can also reduce or suspend benefits! If a worker refuses to be treated for a workplace injury, he/she will be open to having benefits suspended.

WC Act Sec. 10(1) etc.

Third Party Actions

Presently, a worker who is injured in an accident, caused by a party outside the compensation system, may claim compensation or begin his or her own legal action. For example, while driving a delivery vehicle for your employer, someone runs into you and you are injured. You can 1) claim compensation or 2) begin a legal action against the driver that ran into you. One or the other, not both.

Two options for change are being considered:

1. No right to action against any third party;
2. Third party action would be permitted only under narrow circumstances.

The end result will be that additional settlement funds will not be available to injured workers. In the past, if the injured worker claimed compensation, the Commission would take action to collect its costs, provide the accident employer with cost relief, and give the excess money recovered, less expenses, to

the injured worker. This, occasionally, would net the injured worker thousands of dollars \$\$\$.

WC Act Sect 34(2)

Exclusive Jurisdiction

It is proposed that the Commission be given the authority to determine the work-relatedness of a factor that prolongs an injury. When the Commission believes the injury is prolonged by a personal trait, the matter will at some point, cease to be work related. Apparently, this proposed change is to "... ensure the employer is only supporting workers who have work related injuries, thereby ensuring that there are sufficient funds available for workers with work related injuries." *Isn't that what assessments are for ??*

WC Act Sect. 20(1)

Relationship with Appeals Tribunal

The Board of Directors want to be "authorized" to govern the Appeals Tribunal! Members of the Board of Directors, have served as members of the Appeals Tribunal for several years. Advocates have repeatedly argued that this is a conflict of interest. Tribunal hearings are not "fair" when members of the Tribunal are responsible for the policy that denied the claim, etc. in the first place.

Here are some proposed changes that I think are good for the injured worker. Unfortunately, there is more bad than good.

→ non-residents of NB would be covered by compensation;
We are close to the Maine border. Some people lived in Maine and worked in NB. Presently, if they were injured in NB they are not covered. Only residents of NB are covered.

→ "every person" assisting a peace officer in arresting any person ... when requested to do so ... shall be determined to be an employee of the Crown.

This change would ensure that coverage is extended to a wider group who may be called on to assist in an emergency.

Hopefully, this will assist the Commission in providing faster service to injured workers.

These proposed changes, and many more, may be reworded or eliminated over the next little while. I will keep you informed as things progress.

Wendy McGee

NEWFOUNDLAND

The number of injured workers each year who receive Chronic Pain Intervention in Newfoundland and Labrador are less than 50 per year. All injured workers from this province and Labrador have to travel to St. John's for this program. The latest figures from the Workers' Compensation Commission of Newfoundland and Labrador indicated that for the year 1996, only thirty-seven injured workers participated into the Chronic Pain Program. The average cost for this five week program was \$6,245.00 per injured worker, for a total cost of \$231,000.00 for 1996. Travel and accommodations and meals are not included in the above figures, they are paid separately by the Commission. The Newfoundland and Labrador Injured Workers Association is of the opinion that the present policy (CM-09 Chronic Pain) is not being implemented to the betterment of injured workers in this province. This association believes that all injured workers who experience pain from a compensable injury beyond the usual healing time for the injury should be encouraged to have chronic pain intervention before the commencement of any WCC sponsored rehabilitation programs. At present an injured worker may receive work-hardening, ease back to work, upgrading and or formal re-training before any Chronic Pain Intervention. Injured workers who start any of the above mentioned commission sponsored programs often can't participate or complete their program due to their continued pain. There are those injured workers who are taken out of their assigned programs by his or her attending physician after only days into this program because of their continued pain.

La douleur chronique Le nombre de victimes d'accidents et de maladies du travail qui reçoivent des soins pour la douleur chronique à Terre-Neuve et au Labrador est inférieur à 50 par année. Toutes ces personnes doivent se rendre à St. John's pour recevoir leur programme. Selon les dernières statistiques provenant de la Workers' Compensation Commission (WCC) de Terre-Neuve et du Labrador, seulement 37 victimes d'accidents et de maladies du travail se sont prévaluées du programme de douleur chronique pour l'année 1996. Le coût moyen de ce programme de cinq semaines a été de 6 245 \$ par personne pour un coût total de 231 000 \$ pour l'année 1996. Ces coûts ne comprennent pas les déplacements, l'hébergement et les repas, ces frais étant payés séparément par la Commission. La Newfoundland and Labrador Injured Workers Association estime que la politique actuelle (CM-09 Chronic Pain) n'est pas appliquée à l'avantage des victimes d'accidents et de maladies du travail de cette province. L'association en question est d'avis que toutes les victimes d'accidents et de maladies du travail qui subissent des douleurs découlant d'une lésion indemnisable dépassant le temps de guérison normal de la lésion devraient être encouragées à recevoir des soins pour la douleur chronique avant de début de n'importe quel programme de réadaptation financé par la WCC. En ce moment, une victime d'accident ou de maladie du travail peut bénéficier d'un programme de conditionnement au travail, de recyclage ou de formation formelle avant une intervention pour la douleur chronique. Ces personnes qui entreprennent

l'un ou l'autre de ces programmes financés par la Commission souvent ne peuvent pas s'inscrire au programme ou le terminer à cause de leurs douleurs continues. Il y a aussi des personnes qui doivent, sur ordonnance de leur médecin traitant, se retirer du programme qui leur a été assigné après seulement quelques jours à cause de leurs douleurs

NOVA SCOTIA

From the internet.

I have assessed thousands of so-called healthy individuals in a variety of environments and I can tell you that less than 20% of these people display what could be considered even adequate metabolic or structural fitness, never mind kinesthetic awareness and other issues of movement awareness. Does this not likely play a large role somewhere down the line?

I'm really beginning to see how clinical, legal, and moral issues are getting intertwined here in a way that seems to be generating more heat than light.

They end up getting intertwined, not just in this discussion, but in real life, because of the legally and morally difficult questions clinicians end up being asked to play a role in deciding. I'm also seeing here and in other things I'm reading, problems arise because clinicians and researchers don't understand the limitations in the information they're being asked to provide. I don't mean limitations in the sense that "science doesn't yet have all the answers," but in the sense that there are complicated legal issues and good legal reasons for responsibility in legal terms to be considered in certain ways, and clinicians and researchers come at these issues without enough awareness of these issues.

Of course, in treating someone with an RSI, and in dealing with your own RSI, you have to get yourself (your patient) into a state of fitness or body awareness that is not common in our society. Anyone who resists this idea "because it's their employers fault" is being dysfunctional, as Greg says, I think.

I was just asking the medical ethicist down the hallway about this, and she says the particular area I'm asking about is just one giant mess at the moment, with bureaucrats giving themselves permission to do whatever they like, whatever the legal situation is.

The basic idea of what I'm about to quote is that employers have responsibility for workplace injuries even where the worker is vulnerable to those injuries because of factors outside the workplace. There are good legal arguments for this. I'm disturbed at the

thought of clinicians working with the very sensible clinical attitude that patients must take responsibility for their own health, and then importing that attitude into input they are asked to give into legal questions about compensation. The legal issues are different from the clinical issues.

The Nova Scotia report came with an appendix that is a legal review of "Chronic pain syndrome". There is no indication of who wrote it or what its status is.

"Thin skull doctrine":

"Early in the development of personal-injuries law in the Courts it was argued that if the plaintiff victim had a particular susceptibility to the injuries suffered, the negligent defendant ought not to be liable for the full extent of the damage. The question, in effect, was this: if I negligently strike a person in the head in a fashion which in a normal person would have produced only a bruise, but the person I happen to hit has an egg-shell skull and it fractures, must I be liable for the fractured skull? The answer the Courts have given to the question is clearly yes: you must take your victim as you find him.

"The thin-skull doctrine also applies in Workers' Compensation cases and for two reasons. One reason is that permitting compensation to be denied or adjusted because of pre-existing pre-disposing personal deficiencies would very substantially reduce the nature of the protection afforded by the compensation system as compared to the Court system for reasons that would not be understandable in terms either of the historic bargain or of the wording of the legislation. The other reason is that in the compensation system, injured persons become entitled to compensation because they have been engaged as workers. They have functioned as workers with any pre-existing condition they may have had. It seems wrong principle that conditions which did not affect their employment as workers should be relied upon to deny them compensation as injured workers.

"It is acknowledged by the Courts that the principles applicable to thin skulls apply equally to 'frail

spirits'."Decision No. 915 (1987) 7 W.C.A.T.R. 1 (Ont. W.C.A.T.) [at 136].

Just to sum up what I understand by that: If someone forces you to run a marathon, and you die of a heart attack during it, they are still legally responsible for your death (and not just for having held a gun at your head and made you run), even though you might have been sufficiently well-trained to have survived the marathon. This is true in compensation law too: when workers gave up their right to sue in favor of this no-fault system of workers' compensation, they weren't agreeing to a lesser protection of their rights than under the former system, certainly. Furthermore, in the work place, if a degree of fitness that is maintained by less than 20% of the people he sees is not a condition of employment, then it isn't a condition of compensation either. That makes sense.

Furthermore, on the next page, the report says that where there is multiple causation, "the Court will, if necessary, separate out the other factors and award accordingly. The Courts have awarded damages for chronic pain with a condition that developed because of the accident, in combination with other factors."

If that is, in fact, what the Court will do, I don't know where the Nova Scotia WCB gets off declaring that they will not compensate for multi-factorial conditions, like myofascial pain syndrome.

So, with Greg's needlepoint example: If the injury is entirely the result of needlepoint, and not the result of employment, this doesn't matter much for treatment: you treat the injury for what it is. Of course, since part of treatment in this area is changing habits, the person has to change how and whether he or she does needlepoint, and no amount of workplace ergonomic change will affect that.

It is a problem, as Greg is trying to point out, when people's political commitments make it impossible either for them to see that a particular injury is caused and maintained in the workplace or that a

particular injury is caused and maintained outside the workplace.

When it comes to legal questions however, which people like physiotherapists are, apparently, increasingly being asked to play a role in, then it does make a difference what the cause is. An injury from needlepoint plays into insurance, disability leave, and so on just like an injury from a skiing accident on your vacation would. When it comes to disability, accommodation in the workplace, then surely that accommodation, again, doesn't have anything to do with the cause of the injury. I'm entitled to disability accommodation whether I was injured while skiing or injured at work.

Where there is multiple causation, then the Courts will weigh this, with some testimony from medical experts, but it is not up to a medical expert to say that the injury is multi-factorial and therefore not the employer's fault (this is one of the problems with the Murray report). The Court's standards of causation are not the same as the clinician's, and again, there are good legal reasons for this.

Lynette
Sorehand FAQ: <http://www.ucsf.edu/sorehand/>

Letters to the Editor

Dear Editor:

I just received a letter from our WSIB (read WCB - part of the Bill 99 master plan to privatize our public workers compensation system) saying that they were in the process of reviewing chronic pain. An independent scientific study has been commissioned and was due to report by November 1998. The letter was addressed to stakeholder and was a call for nominations to a second panel made up of stakeholders to develop policy and guideline recommendations on how chronic pain should be compensated, prevented and managed. This was in response to initial attempts by the Ontario government to regulate chronic pain out of existence through Bill 99. Illness due to chronic stress at work was explicitly exempted from the act. However, in public hearings held on Bill 99, the government got caught by a group of doctors who appeared before them criticizing what was being done.

It wasn't that long ago in Ontario that the WCB recognized entitlement to chronic pain. As far as I can tell, it was one of the very few jurisdictions in North America to accept that there is such a disability. And it didn't happen because of good will or political intervention. An independent appeal tribunal had been set up in 1985 to hear appeals on WCB matters and it made decisions which pushed the Board to adopt policies. The tribunal's decisions in the late 1980's were based on the facts before it, medical reports, expert evidence, and the claim of an injured worker. The "policy" adopted by the Board was based on limiting entitlement and restricting benefits or assistance that a worker suffering from chronic pain might receive. So much for individual justice and merits of the case.

It seems to me that this is just another step towards complete bureaucratization of the Board. Entitlement is not based on evidence, medical assessments of individuals, and worker complains;

entitlement is about policies, Board authority, and "case management." When people don't get better,

its their own fault. More and more legislation specifies the Board's authority over all medical treatment and judgements of the worker. Whatever happened to informed consent?

Yet at the same time chronic pain is a very widespread experience - it attacks people of all ages. It seems most often around the joints but not exclusively. On the internet I located just one site <http://www.goedhart.com/painresource/painlinks.html> with hundreds of links.

What can we do about this? We know that the experience of pain is real, and we know "policy" is not much better than denial if the policy allows bureaucrats like "nurse case managers" to make the decision.

Injuredworkers.online is interested in your comments and views.

Andy King, USWA

Editor's note: injuredworkers.online is a new website coordinated by a group of injured workers, union activists and community legal clinics based in Toronto. Check it out. Join injuredworkers.online by sending the message (not in Subject line)

subscribe injured -l , your email address without the brackets.

Send message to majordomo@list.web.net

Dear Editor:

I am writing in reference to the article I had written in the 1997-1998 Fall/Winter Issue. It highlighted the fact that I was soon to be subjected to a fourth New Brunswick Workplace Health, Safety and Compensation Commission (WHSCC) Appeal Tribunal Hearing. I also expressed the emotional and financial strife my family and I were facing as a result, aside from my physical disabilities. Unfortunately, my need for a Fourth Appeal Hearing was the result of the WHSCC Board of Directors. Rarely involving itself in such matters, it overruled the previous third Appeal Tribunal decision that reinstated full benefits.

The circumstances which had lead to this whole unnecessary scenario of an emotional, physical, and financial roller coaster ride began on a beautiful Maritime afternoon in September of 1993, at my youthful age of twenty three. Having been employed by one of the largest shipyards in eastern Canada for approximately 6 years, I was severely injured through no fault of my own. While working in a warehouse, a forklift pallet weighing approximately 70 pounds came crashing down on the back of my head and neck region. It had been thrown by a co-worker some 25 feet off a shelving unit.

Subsequently, eight months later, I was *deemed* "capable of returning to my pre-accident employment" by WHSCC. This decision was against the objections of my family physician and specialist. However, there was one extra twist to this story, my employer informed me that my employment was terminated and therefore, I had no employment to return to. It may have been purely coincidental but, I'll leave the speculation to the lay readers of this publication to decide.

As a result of these unjustified and immoral acts perpetrated against me, I appealed WHSCC decision before an Appeal Tribunal on several occasions over a four year period. Although the cards seemed to be overwhelmingly stacked against me, I was bound and determined to fight for my rights. I made a

commitment to myself and to my supporters, never to give up.

Since the newsletter publication of 1997-1998 Fall/Winter issue, I have had my Fourth Appeal Tribunal Hearing and have received its decision.

I am pleased to inform the readers of the publication, that ***Justice has prevailed***. I have re-won my legislative right to be compensated for my injury. It will be retroactive to that beautiful September Maritime afternoon in 1993, which will be forever engraved in my memory as the day that changed my life forever.

Now focusing on justice for others,

Jeffery Collette
Westfield, NB

Editors Note:

Congratulations Jeffery! Your case shows that we all must fight for what is right.

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Editor's Note

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