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Supreme Court of Canada Set to Hear Appeal in Keays V. Honda

By: Hugh Scher

[National ME/FM Action Network to make presentation to the Supreme Court]

On February 20, 2008 the Supreme Court of Canada will hear an appeal from the Ontario Court of Appeal of their decision in Keays v. Honda. The trial judge in this case granted the largest ever punitive damages award in Canadian employment law history when he awarded punitive damages of $500,000.00 against Honda for its outrageous and high-handed conduct founded upon its discrimination and harassment of Kevin Keays and intentional efforts to evade Honda's responsibilities under human rights law. In addition to this, the trial judge awarded damages equivalent to 15 months' reasonable notice, nine additional months of notice for reason of Honda's bad faith in the manner of termination of Keays and an award of reimbursement for legal costs in the amount of $610,000.00, inclusive of a bonus premium of $155,000.00 to Keays' counsel Hugh Scher because of the significant risk assumed and results achieved in this case.

The Ontario Court of Appeal upheld in principle all aspects of the trial judgment finding that Honda wrongfully dismissed Keays from his employment and engaged in bad faith in the manner of termination of Keays. The Court ruled that Honda committed a litany of acts of discrimination and harassment against Keays which justified a substantial award of punitive damages. The Court of Appeal upheld the trial judge's award of 24 months' notice for reason of the wrongful dismissal and bad faith. Justice Goudge, who wrote for a unanimous court on all other issues, would have upheld the trial judge's award of $500,000.00 in punitive damages finding that it was a proportionate response to the blameworthiness of Honda's misconduct, the harm caused to Keays, Keays' particular vulnerability and the need to deter this large employer and others from wrongfully terminating in order to evade their duty to accommodate under human rights law. Justice Rosenberg found that a substantial award was justified but reduced the quantum from $500,000.00 to $100,000.00 finding the award to be disproportional and that certain of the trial judge's findings of fact were not supported by the evidence.

The Supreme Court of Canada is being asked to affirm the trial judge's award of punitive damages as well as to grant additional damages for discrimination and harassment against Honda. Honda seeks to have the decision of the Ontario Court of Appeal set aside.

The Supreme Court of Canada has granted nine intervention applications from disability and women's organizations, human rights commissions and employer representatives who wish to make submissions to the Court with respect to the legal issues in this case.

The National ME/FM Action Network is one of those interveners. Additional interveners include the Council of Canadians with disabilities, the Injured Workers Network of Ontario, LEAF, the Canadian, Ontario and Manitoba Human Rights Commissions, the Canadian Manufacturer's Association, and the Human Resources Professional Association of Ontario.

This case offers the Supreme Court a unique opportunity to consider the relationship between bad faith conduct, discrimination and harassment in the employment relationship and to determine the best way to compensate victims of such conduct and to punish the perpetrators. The Courts below have affirmed the paramount importance of human rights protections to ensure meaningful access to social and economic life for people with disabilities. However, a 30-year-old precedent from the Supreme Court prevents Courts from providing compensation for discrimination and harassment. The Court will be asked to reconsider this decision and to increase the number of tools available to Courts to address discrimination and harassment.

This case raises legal issues of fundamental importance to people with disabilities across Canada and is being watched very closely by people with disabilities and employers across the country because of its significant impact.

The trial award of punitive damages is by far the largest ever in an employment law case and represents one of the largest awards ever in Canadian history. Should it be maintained by the Supreme Court of Canada it would send a significant message to employers and insurers that people with chronic fatigue syndrome and related conditions must be taken seriously and that their claims to equal treatment, respect and consideration and to their just entitlement to benefits must be respected or employers and insurers will face significant penalties.

Note on Author*: Hugh Scher is a partner in the law firm of Scher & De Angelis where he practices civil litigation with a focus on employment, insurance and human rights law especially in the area of disability rights. He serves as counsel to the National ME/FM Action Network, ME Ontario and Fibromyalgia Society of Ontario and has represented dozens of individuals from across the country with Fibromyalgia and Chronic Fatigue Syndrome in disputes with long-term disability insurers, the Canada Pension Plan, employers and Revenue Canada. Mr. Scher served as our counsel in the Lowe v. Guarantee Insurance (2005), O.J. (O.C.A.) and is counsel to Kevin Keays in Keays v. Honda.*

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[**Ed. Note**: As is mentioned in the article, the National ME/FM Action Network has been granted permission to "intervene" in the case between Mr. Keays and Honda at the Supreme Court of Canada. In accepting our application to intervene, the Supreme Court is recognizing the importance of the case to the ME/FM community and is indicating that our organization has a perspective that could be helpful in deciding the case. We were invited to submit a "factum", a written document outlining our views. In our factum, we discuss the nature of accommodation required for ME/CFS, the need for effective remedies for breach of the duty to accommodate and the importance of incorporating the Human Rights Code into contracts of employment.

Recognizing the difficulty and costs of getting expert witnesses familiar with ME/CFS, we ask the court to allow judges to access authoritative websites. Finally, we ask for the opportunity to present our arguments orally at the hearing on February 20. On January 15, the Court announced that we will be allowed to give an oral presentation.

We are very grateful to the law firm Paliare Roland Rosenberg Rothstein LLP who are representing our organization. The firm has extensive experience in both employment law and in appellate work, a perfect combination for this intervention. Chris Paliare and Andrew Lokan have donated considerable time, effort and skill. You can learn more about this Toronto firm at http://www.paliareroland.com/.]

MEDICAL NEWS

ME/CFS & Fibromyalgia May Be Caused by Brain Abnormalities in the "Amygdala"

By : Ashok Gupta MA(Cantab), MSc

I am a researcher based in the UK, and I am currently looking for funding and collaboration for an Independent Clinical Trial on a new type of treatment that I have developed, which seems to be yielding very good results in an initial observational study.

My hypothesis as to what I believe causes ME/CFS & FM has been published in a peer reviewed medical journal:

- Medical Hypotheses Volume 59, Issue 6, 12 November 2002, Pages 727-735, and is also available to be viewed online at http://www.guptaprogramme.com/html/medicalPaper.asp .

I would like to share with you what my medical research seems to indicate. It seems to indicate that ME/CFS and FM are neurological condition caused by abnormalities in a brain structure called the "amygdala" (pronounced a-mig-da-le), which is deep in the unconscious brain near the hypothalamus. I believe that a trauma occurs in the amygdala when someone is under severe stress, and simultaneously experiences a physical trauma such as a virus, bacteria, toxin, or physical injury. The combination of these two effects changes the circuitry of the amygdala, making it continually overreact, constantly stimulating the body's nervous system and filling it with stress hormones and neurotransmitters via the hypothalamus and other pathways, as well as causing malfunctions in the immune system, and is likely to cause altered gene expression. This can then cause secondary effects and symptoms in the body, affecting every single system and organ in the body.

The treatments include various tools and techniques to help "retrain the amygdala". Now I am certainly not saying that ME/CFS or FM is "in the mind", absolutely not! I believe it is a real physical condition with real physical symptoms. The reaction that is occurring is deep in the unconscious brain, and therefore is normally out of our control. However, using powerful techniques, I believe that a patient can regain control over this brain structure, as luckily there is on-going communication between the amygdala and the rest of the brain. The amygdala gradually is retrained, mainly via pathways from the pre-frontal cortex area of the brain, and the over-stimulation of the nervous system is switched off, also causing the immune system to come back to balance. The techniques that I have developed are very different to conventional techniques, and are drawn from many spheres of therapy, and so therefore cannot come under any one banner of treatment, and instead I call them "amygdala retraining" techniques.

I am currently conducting an Observational Study on these techniques with 33 patients, and initially the study seems to show that over 80% of patients significantly improved as a result of the treatments. Already three-quarters of the way through the study, 60% of patients are already at 80-100% functioning. The final results of the study will be published on the website in early 2008, hopefully making it easier to fund a full trial.

My treatment programme is now available as a fully interactive DVD programme with 12 sessions with myself (totalling around 15 hours), with accompanying book and audio CD. This can be purchased on my website for $190, with a pledge that if no significant improvement is noticed within 6 months, it can be returned for a refund.

I would be looking to work with an institution who has expertise of conducting trials in this area, so any ideas would be very welcome. I am currently applying to many different organisations and specialists, but so far without any luck, and I do feel that my processes merit urgent independent assessment.

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Review of "Cellular Hypoxia and Neuro-immune Fatigue" by Dr. David S. Bell, MD, FAAP, published June 2007.

by Dr. Philipa D. Corning, PhD, BSc, CD, and Linda MacDonald, BA, BSc (Physical Therapy)

Dr. Bell's book provides a novel and much-welcomed explanation of the likely pathological processes perpetuating ME/CFS, FM and related illnesses of the neuro-immune fatigue spectrum such as Gulf War illness, Dysautonomia (orthostatic intolerance), Multiple Chemical Sensitivities (MCS) and Lyme disease. He proposes that the three debilitating symptom clusters seen in all of these may be caused by three known functions of a common cellular chemical, nitric oxide (NO). It can function as a neurotransmitter, immune function deregulator, and blood flow modulator. However in excess, it can interrupt or impair associated body functions. Nitric oxide is produced excessively in the cell after viral or other damage to mitochondrial function (the powerhouses within the cell which produce the ATP molecules used for energy to sustain body function). If it cannot be cleared from the cell, or if excess production continues, predictable symptoms will occur, and these are precisely the symptoms one sees in neuro-immune fatigue.

If nitric oxide is indeed the "culprit", then the locus and origin of illness is inside every cell of the body in this spectrum of illnesses. Dr. Bell suggests that the current Western medical paradigm is focused on specific organ malfunction as the cause of disease, and that this paradigm has contributed much to the unfortunate and erroneous invalidation of ME/CFS/FM. Dr. Bell's book presents a comprehensive conceptual paradigm, which predicts that chronic long-term impairments of cellular metabolism will lead to cellular hypoxia and neuro-immune fatigue with predictable symptoms.

Although researchers found ways to distinguish clearly between FM and ME/CFS in 2007 using genomic function profiles (ref), Dr. Bell places them in the same illness spectrum along with MCS, Chronic Lyme Disease, and Dysautonomia (orthostatic intolerance). His thesis is that altered nitric oxide metabolism is the junction box for these illnesses, and that because this is a discreet physiological mechanism which has gone awry, there is the potential to study, alter and possibly correct it. The differences between these illnesses may be due to damage occurring in different steps along the way in the cascades leading to cellular impairment as Dr. Bell suggests, but in essence the process works the same. Simplistically put, insult or injury to mitochondrial function leads to a cytokine cascade (immune response) such as seen in the flu, but this does not switch off as it would normally. Thus, the person becomes caught in a chronically reacting system whose abnormal chemistry perpetuates illness.

Dr. Bell states that "the symptoms of ME/CFS/FM come directly by alterations in the production, concentration, or elimination of nitric oxide." The series of complex chemical cascades leading to excess nitric oxide may begin with an infection, toxic exposure, neurological injury, emotional stress, or physical stress. These initiating events in a genetically susceptible person lead to immune system abnormalities and cause an excessive production of nitric oxide, or inability to eliminate it or its by-products – the reactive oxygen species (ROS) superoxide and peroxynitrite properly. These two by-products are usually changed into hydrogen peroxide and oxygen and eliminated from the body. However, under abnormal circumstances they are poisonous to the mitochondria). Specifically, they interfere with oxidative phosphorylation, which is the production of energy in the mitochondria (the aerobic energy factories in each cell) and lead to cellular hypoxia (the reduced capacity for each cell to transform oxygen into energy).

The role of excess nitric oxide in the body is threefold and could explain the following symptom clusters which are the hallmarks of the neuro-immune fatigue spectrum of illness:

1. Symptom Cluster 1: Vasculopathy - nitric oxide causes decreases in blood pressure and volume; and in cerebral, muscular and cardiac blood flow. In addition, it can lead to cognitive impairment, and orthostatic intolerance.

2. Symptom Cluster 2: Central Sensitization – lowered pain and sensory thresholds with increased reactivity of the central nervous system, resulting in worst case scenarios of full-throttle pain, unbearable light and noise sensitivity, and amplification and distortion of all incoming signals to the brain.

3. Symptom Cluster 3: Cytopathic Hypoxia – This is the impairment of oxidative phosphorylation (or the Krebs cycle, if you recall your high school biology), the root process by which glucose and oxygen from the blood are turned into ATP by the mitochondria (the molecules of energy in the cell necessary for normal function). When the production of ATP is impaired, every bodily function is potentially impaired or at least compromised, in the same way it would be at the onset of shock due to injury or blood loss. The muscles, brain and gut can be expected to be the most severely affected, since they require the most energy to function.

Why should this happen to some people after a virus and not to others? This book discusses the fact that every biochemical reaction in our bodies is controlled or influenced by our genes. Therefore, the expression of every illness is dependent upon our genes eliciting our "host response" to a pathogen (virus, bacterium) or chemical. For instance, about 5 % of people who contract polio will go on to have the typical response we think of: paralysis. This is their host response to the polio virus. More research needs to be done but it is thought that a similar thing happens when one "contracts" neuro-immune fatigue: the host responses (genetic factors that may predispose an individual to the illness) are abnormal and do not switch the immune response off when they should, due to damage of specific genes. Recent research shows that in ME/CFS, specific genes are up- or down-regulated – this can be due to viral or chemical damage. It is apparent however that although "reprogrammed" to malfunction by viral or other damage, susceptible genes may be amenable to repair, and it is up to us to make sure that research is undertaken to explore this option.

Dr. Bell cautions that diagnosis would have to be made and the patient carefully monitored during the first three weeks of viral infection to best prevent onset of neuro-immune illness. In the current situation, even the best diagnostic guides advise doctors to wait 6 months before diagnosis of ME/CFS, FM etc. Furthermore, with respect to health care access, important chemical markers for ME/CFS such as RNase-L are not yet routinely tested/offered/understood by physicians in the health care systems of the USA (or Canada). He believes that change is possible and could be immanent if his theory is put to the test.

Dr. Bell's book is an intelligent, unifying approach to this important frontier of medicine, i.e. treating neuro-immune fatigue by reversing impairments inside the cell which are caused by excess nitric oxide and which have systemic effects. Cellular Hypoxia and Neuro-immune Fatigue proposes rational and plausible answers to what could underlie the symptoms of ME/CFS (Chronic Fatigue Syndrome), Fibromyalgia (FM), Multiple Chemical Sensitivities (MCS), Chronic Lyme disease and Dysautonomia (orthostatic intolerance). This is a book, which one hopes every Canadian doctor, medical student, and public health official reads, gives serious thought to, and discusses with peers.

Cellular Hypoxia and Neuro-immune Fatigue presents compelling reasons why future medical investigation and diagnosis of this spectrum of illnesses must consider mitochondrial damage and its spin-off effects throughout the body, in particular the potential role of nitric oxide, rather than focusing on diagnosis of illness associated with one tissue or organ system.

Reference:

Garcie-Fructuoso FJ, Lao-Villadoniga JL, Fernandez-Sola J, Poca-Dias V, Tejedor D
Genetic Profiles in Severe Forms of Fibromyalgia and Chronic Fatigue Syndrome
- Presented at the 8th IACFS Fort Lauderdale Florida Jan 12 - 14, 2007

Abstract in English:
http://www.clwydme.net/Documents/OlanoECon07.pdf

You can obtain a copy of the book by sending a cheque for $25 to
Dr David S. Bell,
1276 Waterport Road, Waterport, NY,14571.
Alternately, you can order a copy
of the book through Prohealth or Amazon.

Advocating for a Canadian Lyme Disease Strategy

By: Margaret Parlor, Director

The National ME/FM Action Network continues to work with the Canadian Lyme Disease Foundation for better recognition of Lyme disease in Canada. The term Lyme disease is used in two ways - as an umbrella term for a set of infections transmitted by ticks and to refer specifically to Borellia burgdorferi, the primary infection.

Untreated or undertreated Lyme disease can trigger the symptoms of ME/CFS and Fibromyalgia. Greater emphasis on prevention and on early diagnosis and treatment would reduce the number and severity of chronic Lyme cases. There is disagreement in the medical community on how chronic Lyme disease cases should be treated. Some doctors recommend a treatment protocol based on long-term antibiotics. Others hold that long-term antibiotics are ineffective or even harmful. Dialogue and research are needed to reconcile these points of view.

The Public Health Agency of Canada (PHAC) convened a meeting of stakeholders, including the National ME/FM Action Network, in March 2006 to work on a new Canadian Lyme policy. The recommendations of that meeting included setting up committees to explore issues around diagnosis (including lab testing) and treatment, conducting surveillance studies, developing public and professional awareness programs and supporting research development.

The momentum from that meeting was not maintained. The report of the meeting has not been released (as of December 30, 2007), committees have not been established, the Canadian Institutes for Health Research informed us that little money was available for Lyme studies, and the Canadian Public Health Laboratory Network went ahead with guidelines for laboratory testing (see below) without consulting stakeholders.

In an effort to get matters back on track, the two organizations met with a senior advisor to the Minister of Health in Ottawa on November 19, 2007. Ms Patricia Davidson, Member of Parliament for Sarnia Lambton, attended the meeting to learn more about Lyme disease. We are very encouraged by this high level interest and look forward to renewed activity in 2008.

Every cloud is supposed to have a silver lining. The new laboratory guidelines for Lyme disease, produced by the Canadian Public Health Laboratory Network, have two silver linings.

Firstly, the guidelines state that it is possible to come in contact with an infected tick anywhere in Canada. This recognizes studies that have shown a wide distribution of infected ticks in Canada and counters the myth that Lyme disease can be acquired only in known endemic regions.

Secondly, the guidelines recommend that anyone with symptoms of early, disseminated or late Lyme disease should be tested for borellia. This reinforces the recommendations of the ME/CFS and FMS consensus guidelines which state that laboratory testing for Lyme should be considered when people meet the criteria for ME/CFS or FMS.

Despite the two silver linings, the guidelines are still problematic. They send the message that Lyme disease is rare in Canada, a conclusion that is based on wishful thinking rather than proven fact. Assuming Lyme disease is rare may discourage doctors from considering Lyme as a possible diagnosis.
The guidelines also assume that laboratory testing catches virtually all cases of Lyme disease. Many studies have found that Lyme testing procedures miss a high percentage of real Lyme cases. Testing procedures need to be improved (most notably by eliminating the screening test before being allowed to have a Western Blot test) and the limitations of testing need to be better understood and explained. Getting these problems fixed is a priority for our organization and the Canadian Lyme Disease Foundations.

The laboratory guidelines can be viewed on the Canadian Lyme Disease Foundation website, http://canlyme.com.

LEGAL NEWS

Revisiting the T2201 Form, The Disability Tax Credit Certificate

By: George Cameron Caluori

To understand the new Disability Tax Credit Certificate (DTC) T-2201 and how it effects benefits for people with disabilities, it would help to understand how it evolved. The new T-2201 may look generous in its provisions but let's take a closer look.

For people with chronic illnesses like fibromyalgia and Chronic Fatigue Syndrome, the issue has always been eligibility. Can chronic pain or exhausting fatigue qualify for the DTC? Previously, the application form tended to exclude such new emerging illness whose severity may vary over time.

By 2002 the Federal government was spending $400 million per year in tax assistance to about 450,000 Canadians eligible to receive the disability tax credit (DTC) So, when the Tax Court of Canada awarded a DTC to Ray Hamilton because of difficulties he had in procuring and preparing food, the government opted to appeal this decision to the Federal Court (FC) of Canada. Unfortunately, when they lost that decision, they reacted by attempting to change the law.

Hamilton has celiac disease - a permanent intolerance to gluten in his diet. He has to find and buy gluten-free foods, use additional time reading labels, check regularly with product manufacturers to ensure no cross contamination, and spend further additional time and home preparing food, adapting recipes, and cooking.

In March, 2002, the FC agreed that Hamilton was entitled to a tax credit. The Income Tax Act (s.118) allows for a tax credit for persons with a severe and prolonged impairment who, due to their medical condition, must spend an inordinate amount of time performing a basic activity of daily living.

The Minister argued that the term “feeding onself” in section 118 may include food preparation where there is a marked restriction in one's physical ability. But to provide tax relief for the work required in procuring safe foods is to “stretch the words of the statute beyond this meaning,” no matter how severe the medical condition is or limited the food options are. The government argued that allowing a tax credit based on care taken in selecting foods, would be allowing a claim based on personal taste and market availability.

In August, 2002, the Department of Finance responding to the Hamilton decision, announced that it was considering amendments to the Income Tax Act to restrict “feeding oneself” to the act of putting food in one's mouth and “dressing oneself” to putting or removing one's clothing. The intent was to ensure that the tax credit remains available to individuals who are severely restricted in their daily activities and not to reduce the government's support. Unfortunately, however, the amendments would effectively limit the broader and compassionate application of the Federal Court.

The response form people with disabilities, disability associations and advocates, other stakeholders, and some MP s was intense and immediate. In November, 2002 the controversial proposal was withdrawn, replaced by a round of new consultations to develop a revised proposal. The deadline for submissions on this consultation process was January, 2003. The mandate was now to make the tax system fairer for people with disabilities and the people who support them.

While the notion of a consultation process was encouraging, the work was in fact already done. In

March, 2002, the Standing Committee on Human Resources Development and the Status of Persons with Disabilities released *Getting it Right for Canadians: The Disability Tax Credit*. The report was based on hearings that included various disability associations, advocacy groups, Canada Custom Revenue Agency (CCRA), and of course the Department of Finance. The Committee unanimously confirmed the disability community's views regarding the unfair practice of the CCRA in administering the tax credit and recommended reviewing the administrative process. If the purpose of the government was to make the tax system fairer to people with disabilities, then the Standing Committee had already achieved that goal. So why another committee?

In April 2003, the government established a second committee, The Technical Advisory Committee on Tax Measures for Persons with Disabilities, to provide advice to the federal Ministers of Finance and National Revenue on how to address issues related to tax measures for persons with disabilities. In December 2004, the Committee released its final report, *Disability Tax Fairness*, in which it made 25 policy and administrative recommendations focussing on issues relating to eligibility for the disability tax credit.

Previously, the DTC eligibility criteria require that an individual have a marked restriction in at least one basic activity of daily living. In practice, the individual must be unable, or take an inordinate amount of time to perform the activity, all or substantially all of the time. For example, the individual must be unable to walk, be deaf, or require tube feeding for nutritional sustenance.

The new DTC provides tax relief to individuals who, due to the effects of a severe and prolonged mental or physical impairment, are markedly restricted in their ability to perform a basic activity of daily living, even with therapy (averaging at least 14 hours per week). Individuals are markedly restricted if, at least most of the time, even with therapy or appropriate devices and medication, they are unable to perform a basic activity of daily living (ADL) or they require an inordinate amount of time to perform that activity. The basic activities of daily living currently recognized in the Income Tax Act are: walking; feeding or dressing oneself; perceiving, thinking and remembering; speaking; hearing; and eliminating bodily waste.

The DTC provides for a substantial medical report of 7 pages where previous versions of the DTC required only a 2 page report and made no mention that the criteria " unable to perform" was interpreted in the legislation as "require an inordinate amount of time to preform activities of daily living". The Tax Court did clarify the legislation, stating what had always been argued by advocates at the Tax Court level. The question is has the change resulted in an increase of tax credits for people with disabilities? Only Revenue Canada Agency can tell us that by reviewing their statistics.

In its 2004 report, the Technical Advisory Committee made several recommendations regarding the eligibility criteria for the DTC. For our purpose 2 recommendations were significant; clarifying the legislation on how impairments are to be understood, and extend eligibility by recognizing that a marked restriction in an ADL is also the cumulative effect of impairments for individuals with multiple restrictions.

So how does the Department of Finance understand a particular impairment, "cognitive impairment" for example. A marked restriction of a mental impairment is one where a beneficiary takes significantly longer than an unimpaired person, most of the time, even with support systems, to recall basic personal information and simple instructions, adapt for self-care, health and safety and common transactions, or taken together problem-solving, goal-setting and appropriate judgement memory. Examples include, need assistance for simple transaction, like banking; unable to leave the house due to anxiety; a restriction in problem-solving or judgement that restricts adaptive functioning; requires daily supervision due to psychotic episodes and other complications.

Similarly, the daily activity of feeding oneself is markedly restricted if most of the time, even with appropriate aids, it takes significantly longer than an unimpaired person to prepare meals or feed oneself due to significant pain and decreased strength in the upper limbs. With respect to feeding only:

> "Feeding oneself does not include identifying, finding, shopping for or otherwise procuring food.... Feeding oneself does include preparing food, except when the time associated is related to a dietary restriction or regime, even when the restriction or regime is required due to an illness or health condition."(Disability Tax Credit Certificate, Form T2201 1 E (06), Page 5, Canada Revenue Agency)

Again, the daily activity of dressing is markedly restricted if most of the time, even with appropriate aids, it takes you significantly longer than an unimpaired person to dress yourself due to pain and decreased dexterity but does not include identifying, finding, or procuring clothing. The developments won in the Hamilton case are now excluded.

The second key recommendation concerns the cumulative effects of various restrictions. Based on the advice of the Technical Advisory Committee, eligibility extended the DTC to include individuals with severe and prolonged impairments in mental or physical functions who are restricted in more than one activity of daily living where the cumulative effect is equivalent to a marked restriction. Again, not new but well advance in practice before the Tax Court adjudicator.

So, for example, someone with FM would experience constant fatigue, pain related mobility issues and secondary depression. Individually such symptoms would not represent a marked restriction in daily activities, but taken together, the cumulative effect would be equivalent to a marked restriction of a specific activity of daily living. Indeed such persons incur related costs just like those with a marked restriction in one ADL. As a consequence of such changes, RCA states, “It is estimated that approximately 50,000 individuals will become eligible for the DTC as a result of this measure” (Budget 2005, Annex 8, Tax Measures: Supplementary Information) Again, only the RCA can tell us. But were such applicants not already eligible by virtue of the legislation?

Certainly 50,000 new eligible claimants is significant. But in fact these recommendations are not new. Any advocate would know that such argument were always available before the Tax Court on informal appeals. The legislation s118 already provided for it. It was always the case that a person with FM, for example, could argue that both chronic pain (under the ADL category of Mobility) and memory dysfunction (under the category of Cognitive impairment) resulted in a cumulative disability that qualifies for the DTC. Moreover, a mobility impairment in FM, it was argued, should be “conceptualized” or understood as markedly restricted for taking an “inordinate amount of time” to perform as exhaustion caused frequent breaks and a lengthy recuperation time. Revenue Canada or the Department of Finance should have known from these Tax Court cases and appeals from informed advocates that they needed to be more explicit, more fair to disabled applicants. But after all, the role of the Committee is only to clarify existing legislation and not expand eligibility.

While the controversial proposal to restrict eligibility was withdrawn in 2002 by the Finance Department, the recommendation of the Advisory Committee reintroduced the restrictions. The Department restated what was always available and appears to act generously while at the same time moving to limit the prospects of disabled persons achieved through the Hamilton decision. In effect, the department accomplished by committee and policy directive what was blocked in Parliament and lost at Tax Court, successfully implementing its interpretation of eligibility and “overruling” the Hamilton decision, all while appearing to be generous. Yet, as the committee merely clarified the departments understanding of the legislation and did not introduce new regulations or legislation, then the battle can still be joined at the Tax Court Level. It is not a bureaucratic decision, an improved RCA form or even departmental policy that determines whether an individual qualifies for the tax credit but the enacting legislation interpreted by an informed adjudicator.

It should come as no surprise that what could not be achieved directly through parliamentary legislation was achieved indirectly through a committee. In the end, the good news is the argument for eligibility for people with disabilities, including FM and CFS, has not really changed. Just more clarification is needed in your application and medical report and arguments will continue in Tax Court. As was already pointed out, whether the acknowledgement by RCA of a broader base for qualification as indicated in the legislation, has resulted in an increase of benefits, well, only RCA can tell us that.
The above revised form is available at your regional CCRA office, toll free at 1-800-959-2881, or from their website at
http://www.ccra-adrc.gc.ca/E/pbg/tf/t2201/t2201-03e.pdf

[***Note on author***: *George Cameron holds a graduate degree in philosophy and a post degree diploma in Regulatory Law Administration. For almost 14 years, he has represented people with disabilities across the country before CPP Review Tribunals, Pension Appeals Boards, Disability Tax Credits appeals, Workplace Safety and Insurance Board, among other government agencies. George can be reached toll free at 1-888-734-7776, or 1-613-237-2296, Fax 1-613-237-5636 or at* ***georgecameron@rogers.com***]

How to Improve your CPP Application

By John Wodak

If you were a judge, and half of all your decisions were appealed to a higher court, would you be offended? Probably not; we live in a litigious society, and there are people who will use the legal system as long as they have money to pay a lawyer. If the appeal court reversed your decision in half of all appeals, would you at least begin to wonder if you might be doing something wrong? I hope so. Yet in the CPP appeal process, more than half of all reconsideration (first appeal) denials are appealed to a review tribunal, and review tribunals are currently allowing more than half of the appeals they hear.

Of course, the comparison is not exact. But the principle is the same, and it’s worth asking what review tribunals do differently, which so often leads to a different decision. At least part of the answer lies in the fact that a review tribunal is the first point in the process at which the applicant meets the decision-makers face-to-face. Why should this make a difference?

Any successful application for CPP disability benefits must establish two important facts: you must have a medical condition, and this condition must prevent you from "regularly pursuing any substantially gainful occupation". The first fact needs to be certified by a physician, but the second - no matter how it is presented - relies on the applicant's testimony. A completed application contains this testimony, but my experience suggests that the CPP adjudicators give relatively little weight to the applicant's information when reaching their decisions. The standard CPP denial letter gives a summary of the medical evidence and a conclusion, " . . . you may not be able to do your own job, [but] I concluded that you should be able to do some type of work." This one sentence is essentially the only reference to all the information provided by the applicant in the long (and usually confusing) "Questionnaire for Disability Benefits" form.

If the review tribunal members and/or your representative know their job, they will ask the right questions: "What are your main symptoms, and what aggravates them?" "How often are you completely incapacitated by pain or fatigue?" "Are you able to retain and follow verbal instructions?" "What treatments have you tried, and what was the result?" "Did you try to continue working after you became ill; if so, what happened?" Even the old chestnut, "Describe a typical day/week/month," enables you, the applicant, to explain what your life is like, and why you cannot work any longer. All this information is (or ought to be) in your answers to the Questionnaire that the adjudicators have recorded but not used. And if the review tribunal members believe your answers, they will allow your appeal.

The obvious solution to all this is for the CPP adjudicators to give more weight to the information which you have provided to them. Until this happens, here are a few tips:

1. Make a list of your main symptoms. People with CFS/FM can conveniently use the checklists in the consensus documents.
2. For each symptom, identify how it affects your ability to function. For example, "fatigue" or "post-exertional malaise" will limit you to only a few hours' activity per day; "symptoms vary in severity" will mean you are unable to maintain a regular schedule; "cognitive dysfunction" will result in the loss of previously familiar skills; "pain" will restrict your ability to sit at a desk and/or concentrate.
3. In addition to transferring all this information to your application, take it to your doctor and ask him/her to use it when completing the medical questionnaire. If you have the opportunity, give it to your specialist(s) and ask them to include it in any reports they may send to your family doctor. Most doctors dislike writing reports (and who can blame them?), and any help you can give them will usually be appreciated.
4. On the second page of the Questionnaire there is a question, "Because of your medical condition, did you have to do a lighter job or different type of work?". If you are typical, you will have used all your sick leave and vacation time, and may even have taken unpaid leave in a desperate attempt to keep on working. Enter this information here - it's the best place for it.

This isn't rocket science, nor will it guarantee success. But at least it will help to put all the facts on the table.

*[**Note on author**: Mr. Wodak has been working as a volunteer advocate since 1996.*
jwodak@techwcs.com]

National Lawyers' Roster - Addition

ALLAN M. KAUFMAN, BA, LLB, BCL (oxon)

Specializes in employment law. Experience with fibromyalgia cases and chronic pain Initial consultation: Free
The Thomson Bldg1105, 65 Queen St. West.Toronto, Ontario M5H 2M5
Tel: 416-364-1068 Fax: 416-364-1341
Email: **a.kaufman@bellnet.ca**

Book

Cellular Hypoxia and Neuro-immune Fatigue
ME, CFS, FM, MCS, Orthostatic Intolerance/Dysautonomia, Chronic Lyme Disease

By : Dr David S. Bell, MD, FAAP, *author of The Doctor's Guide to Chronic Fatigue Syndrome*
WingSpan Press, 2007, 84 pages

You can obtain a copy of the book by sending a cheque for $25 to Dr Bell,
1276 Waterport Road, Waterport, NY,14571, USA

Alternately, you can order a copy of the book through Prohealth or Amazon.

NETWORK NOTES

IME/FAE Registry Submission

The **National ME/FM Action Network** continues to urge those who have attended an **Independent Medical Examination (IME)**, **Functional Abilities Evaluation (FAE)** or any other form of assessment at the request of an insurance company, Canada Pension Plan (CPP) or Workplace Safety & Insurance Board (WSIB) to fill out our 7-question, confidential, **Independent Medical Examination Registry Submission Form** so that the names of the doctors and healthcare professionals who evaluated you can be put on record. Patients, doctors, lawyers, advocates, support groups wishing to receive a copy or copies of the Form, or to inquire about specific IME doctors, please contact: **National ME/FM Action Network** – Or download the Form from our website at **www.mefmaction.net**

MEMBERSHIP: $25.00 per year, which includes quarterly newsletters
Payment can be made by CHEQUE, VISA or MASTERCARD.
Do not email credit card information.
NATIONAL ME/FM ACTION NETWORK
3836 Carling Ave., Nepean, ON K2K 2Y6, Canada
Tel/Fax: (613) 829-6667 E-mail: ag922@ncf.ca
Web: http://www.mefmaction.net

RESOURCES

Complete Original Consensus Documents *:*

-FMS Consensus Document - US$24.95

"The Fibromyalgia Syndrome: A Clinical Case Definition for Practitioners".
Haworth Press, 2004. (soft cover book)
ISBN: 0-7890-2574-4
Phone: **800-429-6784** Fax: **607-771-0012**
Email: **orders@haworthpressinc.com**
Online: **http://www.haworthpress.com/store/product.asp?sku=5342**

-ME/CFS Consensus Document US$14.95

"MyalgicEncephalomyelitis/Chronic Fatigue Syndrome: Clinical Working Case Definition, Diagnostic and Treatment Protocols".
Journal of Chronic Fatigue Syndrome, Vol. 11, No. 1, 2003.Haworth Press 2003/2004
ISBN: 0-7890-2207 9
Phone: **800-429-6784** Fax: **607-771-0012**
Email:**orders@haworthpressinc.com**
Online:**http://www.haworthpress.com/store/product.asp?sku=4958 CFS46**

Overviews of the Consensus Documents:

Fibromyalgia Syndrome, 24 pp, 2006
Chronic Fatigue Syndrome, 20 pp, 2006

can be ordered from **Marjorie Van de Sande** at mvandesande@shaw.ca or at
151 Arbour Ridge Circle NW, Calgary AB T3G 3V9.

ME/CFS DVD Resources

Prices include shipping & handling

- **Dr. Kenny De Meirleir - Physicians' full day workshop $80.00. This includes 4 DVDs and a CD**

  Canadian Consensus Guidelines for Diagnosis, Assessment and Treatment of ME/CFS -What they are and how to use them.

    - Research Update
    - Diagnostic Work Up and Treatment Algorithm
    - Case Examples and Discussion
    - CD of Slides

- **Dr. Kenny De Meirleir : Patients' lecture $25.00**

Payment: must be by **cheque** or **money order** payable to **Marjorie van de Sande**

Mail it to her at **151 Arbour Ridge Circle NW, Calgary AB T3G 3V9.**

Network Resources

The following resources can be ordered from the National ME/FM Action Network. Prices include shipping and handling. Cheques should be made payable to the National ME/FM Action Network or you may pay by VISA or MasterCard.

Quest Collections

By popular request, the **National ME/FM Action Network** has published two collections of important articles which have appeared in **'QUEST'** newsletters. The articles in each five-year collection have been grouped into sections according to their focus.

Quest Collection I: presently out of print

Quest Collection II (1999 – 2003): $38.00

TEACH-ME: A Sourcebook for Teachers (Second Edition): $22.00 *Discount on bulk orders*
With Dr. D. S. Bell, Dr. B. M. Carruthers and the TEACH-ME Task Force (teachers with ME/CFS and/or FMS)
This educational resource book will enhance teachers' and parents' understanding of ME/CFS and FMS in young people, and assist educators in developing educational modifications and programs.

The Canada Pension Plan Disability Benefits Guidelines: $7.00.

New up-dated guidelines have been designed to assist those disabled by ME/CFS and/or FMS applying for Canada Pension Plan Disability Benefits. It will help you understand the criteria, important items to include and walks you through the various steps of the process.
Legal Disability Manual: **$60.00**
Approx. 400 pages *Editor: M. van de Sande*

The Legal Disability Manual includes sections on: FMS and ME/CFS Overview; The Medical Report and Expert Witnesses; Independent Medical Examinations; CPP Disability Benefits, Disability Insurance and Other Legal Articles; Case Law; Psychological Factors, Tests, and Treatments; and Research Abstracts. Many of the articles have been written specifically for the **National ME/FM Action Network** by lawyers and doctors. Our Canada Pension Plan Disability Benefits Guidelines are also included in the Legal Disability Manual. This manual is a must for those in litigation.

<u>DISCLAIMER</u>: The NATIONAL ME/FM ACTION NETWORK serves as a clearing house for information on Myalgic Encephalomyelitis / Chronic Fatigue Syndrome and Fibromyalgia. Some of the information contained herein is intended to help patients and their physicians make informed decisions about their health. However, the NATIONAL ME/FM ACTION NETWORK does not dispense medical advice or endorse any specific medical hypothesis or product and assumes no responsibility for any treatment or action undertaken by its readers. Discuss medical treatments with your personal physician.