2012-315

Representative: Mary Ann Burke-Matheson, BPA
Decision No: 100001718315
Decision Type: Entitlement Appeal
Location of Hearing: Charlottetown, Prince Edward Island
Date of Decision: 11 July 2012

The Entitlement Appeal Panel decides:

OBSTRUCTIVE SLEEP APNEA

No entitlement granted for the disability as it is not a consequence of the pensioned condition of rheumatoid arthritis.
Section 46, *Canadian Forces Members and Veterans Re-establishment and Compensation Act*.

Before:	Brent Taylor	Presiding Member
	J.M. Walsh	Member
	Dorothy O'Keefe	Member

Original signed by:

Reasons delivered by: ———————————

Brent Taylor

INTRODUCTION

The Appellant is seeking disability entitlement for his Obstructive Sleep Apnea, which he believes developed as a consequence of an already-pensioned disability.

PRELIMINARY MATTER

The hearing opened on 5 July 2012 with the Advocate present. As is explained below, the hearing was adjourned to permit the Advocate to review the Board's resource material on Obstructive Sleep Apnea (OSA), as that material had been inadvertently omitted from the Statement of Case during its compilation. The hearing reconvened to consider the submissions of the Advocate on the resource material on 11 July 2012, at which time the decision below was reached.

ISSUE

The Appeal Panel must determine, from the evidence before it and the application of sections 45 and 46 of the *Canadian Forces Members and Veterans Re-establishment and Compensation Act*, whether the Appellant's OSA is consequential to his rheumatoid arthritis.

EVIDENCE AND ARGUMENT

The Appellant, now 55 years old, holds pension entitlement for a variety of disabilities and is presently assessed at 100%, 52% of which is for rheumatoid arthritis (RA). It was granted, at two-fifths, in a 1999 decision by a Review Panel of this Board.

Ten years later, following a sleep study in September 2009, the Appellant was diagnosed with "severe sleep apnea." On 23 August 2010 the Appellant filed an application for a disability award with Veterans Affairs Canada (the Department), attributing his OSA to weight gain caused by his immobility, which itself was due at least in part to his RA.

The Department, after consulting a medical advisor on its staff, denied entitlement in a decision of 6 January 2001. In its decision letter [P62-63] the Department wrote in part as follows:

- Current medical literature indicates that Obstructive Sleep Apnea occurs when the muscles in the back of the throat relax. The risk factors for Obstructive Sleep Apnea cannot be related to your military service duties or activities. Some of these factors include: excess weight, neck circumference, a narrowed airway, gender, age and family history.
- The October 2010 Medical Questionnaire submitted with your application records a diagnosis of Obstructive Sleep Apnea.
- However, in consultation with our Departmental Medical Advisory it is noted that your sleep disorder is secondary to non-service related factors and is not related to your pensioned condition of rheumatoid arthritis.

After being denied entitlement by Veterans Affairs Canada in the first-level decision, the Appellant took it to a Review Panel of the Board on 17 August 2011. Following his hearing, the Panel ruled to affirm the denial of entitlement for both disabilities, and wrote in part as follows [P81-82]:

> In particular, both the specialist, Dr. Rebello, and the Applicant acknowledged the significance of the Applicant modifying his diet so as to lose weight. The Applicant says that he plans to do this after Labour Day. Further, the Applicant has acknowledged that swimming is an exercise he can comfortably pursue, and that this would assist in weight loss.
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> The 18 February 2011 letter from Dr. Pacis does not advance the Applicant's case, as it overlooks entirely the role of the Applicant's diet in his weight gain and also it attributes his lack of activity to his rheumatoid arthritis. The Applicant, himself, acknowledged that it is because of lack of motivation, not because of his arthritis, that he has not pursued an exercise program such as swimming.

The above decision was then brought to this Entitlement Appeal Panel of the Board, which held a hearing on 5 July 2012. The Advocate submitted written arguments, accompanied by new evidence and appeared in person to make submissions.

The Advocate put forward a new letter from Dr. Ruth B. Pacis dated 3 January 2012 (EA-W1) as well as a written statement from the Appellant dated 1 December 2011 (EA-W3).

The Advocate summarized the Review Panel's reasons and reminded the Appeal Panel that the Appellant was also pensioned for osteoarthritis of his left knee (consequential also to his RA), which was now "bone on bone" according to his assessment for that disability.

During the hearing, the Panel noted that the Statement of Case did not contain a medical resource package with generic medical information concerning the causes and features of OSA. The Panel then referred the Advocate to an Internet article which provided basic generic medical information entitled "Obstructive sleep apnea" from Mayo Clinic.com that would be considered by the Panel.

The Advocate objected to the introduction of the material, and submitted that the information already in the record was all that was required for the Panel to come to a decision. She submitted as well that the production of the Mayo Clinic article went against procedural fairness as she had no time to prepare submissions on the material.

The Panel immediately advised the Advocate that it would give her whatever time she needed to review the article and to determine whether she would make additional submissions based upon it. She was also

advised that she could return on some later date to conclude her oral submissions. However, the Advocate announced she would prefer to “withdraw” the case.

The Panel then advised the Advocate that withdrawals are not at the discretion of the Advocate. Since the hearing had already begun and the Panel was seized with the matter, the Panel noted that the appeal could not simply be withdrawn by the Advocate without the Panel’s leave. The Panel indicated that it would take a brief recess to consider the request and asked the Advocate to absent herself from the hearing room so that the Panel members could deliberate on whether it was appropriate to grant her request to withdraw the appeal.

After the recess, the Panel invited the Advocate back into the hearing room and advised her that the case would continue, and that she would be offered an adjournment so that she could review the article on OSA, and determine whether it raised any new issues that she wished to address in her submissions. The Panel noted that the resource material would not contain controversial information in that it represented the widely-known medical consensus on the causes of sleep apnea. The Panel noted that given the extensive experience of Board members and the Bureau of Pensions Advocates with disability claims concerning this particular diagnosis in recent years, the information in the article would not appear to be novel, or particularly complex.

The Advocate replied that to adjourn the hearing would go against section 40 of the *Veterans Review and Appeal Board Act*, which charges the Board to deal with cases informally and expeditiously. She told the Board she was owed notice of the Mayo Clinic material earlier and that she was “angry” with the fact that there had been several other cases before the Board recently where there had been adjournments in order to consider evidence and to allow advocates to make further submissions. The Advocate told the Panel that this placed her in the position of having to explain to clients why their cases did not always proceed to completion on the day set down for the hearings. The Advocate also raised the possibility of the Board requesting independent medical advice under its powers as provided by section 38 of the *Veterans Review and Appeal Board Act*. Finally, the Advocate took the position that, with the inclusion of the Mayo Clinic article, the Panel appeared to be setting itself up as an adverse party in what is supposed to be a non-adversarial process.

The Panel reminded the Advocate that section 38 was a discretionary rather than a mandatory provision and that this was not an appropriate case for an independent medical opinion as the information to which she was now objecting merely spoke to the basic etiology of OSA, which was not a controversial point.

The Panel also noted that the covering explanation that accompanied the pre-hearing Statement of Case included a reference to all of the generic medical information and resource material that the Board typically considers when making its decisions. The Panel reviewed with the Advocate that it had become standard practice for the Board to include generic medical information on conditions or disabilities in cases where the Department’s file did not already explain the nature of the condition, and where there was not a current Departmental Entitlement Eligibility Guideline or a Medical Guideline on the claimed disability or condition subsequent to the Federal Court decision in *Deschênes v. Canada (Attorney General)*, 2011 F.C. 449.

The Panel reiterated that since the generic medical information on OSA from the Mayo Clinic had not been included in the Board’s Statement of Case when the documentation in the case was assembled prior to the hearing, the Advocate would be permitted to take whatever reasonable period of time that she needed – even beyond the standard 30 days if requested – to make submissions on any new points raised by the Mayo Clinic article.

Nevertheless, the Advocate maintained her objection on the basis of procedural fairness and asked that her objections and interventions be noted. The Panel acknowledged her objections and assured her they would be fully addressed in this decision (see below).

The Panel marked the Mayo Clinic article as EA-W4, and presented a copy to the Advocate. The hearing was adjourned, awaiting word from the Advocate that she was either ready to resume oral submissions or, in the alternative, to provide a further written argument on the Mayo Clinic information.

On 11 July 2012, six days after the first hearing and after the Advocate had time to prepare additional submissions, the Panel was reassembled and the hearing continued. The Advocate, in her appended written submissions, referenced her previous oral and written argument and requested an award of partial entitlement for the Appellant’s OSA, noting that the Mayo Clinic article, Dr. Déziel, and Dr. Pacis were all in alignment on the issue of the connection between sleep apnea and obesity. The Panel

acknowledged the Advocate's additional comments, and advised her that it had no additional questions for her, beyond those it had already asked when the hearing began on 5 July 2012.

ANALYSIS AND REASONS

In making the decision below this Panel has fully applied itself to the obligations as set forth in its enabling statute. Section 39 of the *Veterans Review and Appeal Board Act* reads as follows:

> 39. In all proceedings under this Act, the Board shall
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> a) draw from all the circumstances of the case and all the evidence presented to it every reasonable inference in favour of the applicant or appellant;
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> (b) accept any uncontradicted evidence presented to it by the applicant or appellant that it considers to be credible in the circumstances; and
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> (c) resolve in favour of the applicant or appellant any doubt, in the weighing of evidence, as to whether the applicant or appellant has established a case.

As the Federal Court has noted in a number of cases (and recently affirmed in *Carnegie v Canada (Attorney General)*, 2012 FEDERAL COURT 93, Near J.) the Appellant is to establish, on a balance of probabilities, entitlement to an award.

Under sections 45 and 46 of the *Canadian Forces Members and Veterans Re-establishment and Compensation Act* entitlement is granted in fifths, to reflect the degree to which a claimed disability can be found to have arisen out of or been directly connected with an already-pensioned disability.

The Panel has carefully reviewed the historical and contemporary evidence in this case and has concluded the Review decision should be affirmed. The Panel will provide detailed reasons addressing the merits of the appeal on the disability claim later in this decision. First, however, the Appeal Panel will address the various issues raised by the objections made by the Advocate when the Panel offered her the Mayo Clinic article when the hearing first commenced on 5 July 2012.

Issues arising at the hearing

The Advocate objected to the late arrival of the Mayo Clinic information, and the Panel agreed that it would not be fair to expect her to make specific submissions on it immediately at the hearing. The Panel offered the Advocate as much time as she needed to review the article, and ensured her it would not come to a decision until she had adequate time to add any additional material to her submissions.

However, the Panel also notes that the issue of "current medical literature" was in fact mentioned in the Department's decision of 6 January 2011. The issue to be determined in this case is whether the Appellant's sleep apnea is directly connected with his rheumatoid arthritis. Whether there is advance notice provided to the Advocate or not, the issue does not change.

Pensions advocates and other representatives are expected to be familiar with medical consensus as to the causes and etiology of the claimed condition so that they are prepared to make arguments on their client's behalf to establish that the claimed disability may be linked to their client's military service. Knowing the cause or causes of the disability or disabilities being claimed is simply a part of the preparation for the case that experienced advocates are expected to provide to their clients. This is required regardless of whether the Board includes generic medical information in their client's Statement of Case or not.

In this case, the literature itself was not made part of the Statement of Case and the Panel's offer of the Mayo Clinic article at the Appeal hearing was done to ensure that the Advocate had access to the very same information as the Panel and to enable the Advocate to determine whether the Mayo Clinic article raised any new issues that she wished to address at the hearing or before the decision was made.

Ultimately, cases before the Board should not and cannot proceed in an informational vacuum. While there may be some debate as to the best procedure for identifying the generic medical information that is used by the Board in preparing for its cases, the Board is entitled to rely on generic and widely-

available medical information. This point is not in issue and it was most recently confirmed in the *Deschênes* decision, which the Panel will discuss below.

The Deschênes Decision

In the *Deschênes* case, the Federal Court concluded that the Board erred because it had not given the applicant an opportunity to make submissions on a specific medical issue that the Panel had apparently identified as a result of consulting medical texts after the appeal hearing.

The issue in the *Deschênes* case was the facts of the applicant's case had established that he suffered from a particular non-service-related medical factor or condition that was recognized as a known cause of the claimed condition. Although this factor had been an issue in the applicant's case from the outset of his claim, it had never been specifically raised or discussed in any detail in the earlier decisions which were rendered by the Minister and by the Board on review, when they denied his claim.

It was not until the Board's Appeal decision that the issues raised by the presence of this medical condition was specifically identified. The appeal Panel cited certain external generic medical resources to confirm the prevailing medical consensus as to the known causes for the claimed disability. The appeal Panel also relied on that external medical information when it rejected the applicant's expert medical opinion evidence on the basis that the expert's opinion was not credible because it failed to address the role of the non-service medical condition.

When the Federal Court reviewed the Board's appeal decision in *Deschênes*, it noted that the Board was entitled to refer to, and rely on, generic medical information in order to weigh medical evidence and to identify medical issues that were raised in the case. However, the Federal Court also noted that the Board must always provide an opportunity to the appellant to address any potential medical issues that were identified as a result of consulting the information, before the Panel decides the case. The Federal Court concluded that the Board erred in *Deschênes* because it never provided the applicant in that case with an opportunity to make submissions on the specific medical issue which the appeal Panel had identified in its decision, before the Panel rendered the decision.

The issue that was identified by the Federal Court in *Deschênes* can be attributed, in part, to the fact that there was often little or no information concerning the etiology of the claimed disability or medical condition in the Minister's decision or in the Minister's file. Prior to the *Deschênes* decision, it had always been standard practice for advocates, Board members and other decision-makers to consult and review generic medical information from *The Merck Manual* and other medical resources when preparing for hearings. However, prior to *Deschênes*, this generic medical information was not actually provided or reproduced as part of the hearing record unless the advocate or representatives chose to adduce it as part of the evidence that was submitted to the Board at a hearing.

Accordingly, although advocates frequently present generic medical information as part of the evidence they relied on to support their case at the Board's hearings, there was no requirement that this be done, nor any consistent practice to this effect.

It should therefore be noted that prior to the Federal Court decision in *Deschênes*, advocates and Panel members routinely reviewed generic medical information in preparing for a case or in making the decision, but the generic medical information itself did not become a tangible part of the hearing record in the sense that it physically appeared in the record unless it was adduced by applicant or appellant at the hearing. Furthermore, the generic medical information was not included as part of the Board's pre-hearing documentation that is known as the Statement of Case prior to the hearing.

After *Deschênes*, the Board reviewed its pre-hearing processes to identify how it could better ensure that medical issues would be fully canvassed at the Board's hearings. It concluded that the real issue raised by the *Deschênes* decision was how the Board could better ensure or facilitate the identification of medical issues in advance of, or at, the hearing. The Board determined that this objective could be promoted by including basic medical information in its Statement of Case. The Board concluded that the need to include basic, generic medical information arose in particular where there were no Departmental Entitlement Eligibility Guidelines or Medical Guidelines that addressed or dealt with the claimed disability or condition. The Board then began to include basic generic medical information in its Statement of Case as standard practice.

As well, the Board also began to include a document entitled "Information That Will be Considered by the Board in Deciding Your Case" which describes the Statement of Case itself, and medical and other

resources used by the Board. It contains a detailed two-page summary of the various medical resources and texts are used as medical reference materials by Board members when hearing cases. It also includes a list of the Board's "main" decision-making tools, which consist of primary legal sources as well as Departmental medical guidelines and directives. The summary also outlines discussion papers, external reference books and documents, other documents, and finally "Medical Sites." This last summary includes references to the Mayo Clinic, *The Merck Manual*, and *The New England Journal of Medicine*.

The provision of this additional material is similar to the National Documentation Packages, Issue Papers and Country Fact Sheets used by the Immigration and Refugee Board. Applicants who may not have access to these resources would be, when a package is included in their record, able to see this information for themselves.

The inclusion of this medical resource material was a direct response to the issues identified by the Federal Court in *Deschênes*. It should be noted, however, that the presence or absence of generic medical information and material in the Board's Statement of Case does not change or affect the medical issues that are raised in the case. It merely shines a more direct light on them for the benefit of appellants. Advocates, being experienced in the preparation of disability cases, are presumably well aware of the need to identify and address all relevant medical issues raised in their client's case as part of preparing their evidence and arguments in the case. Indeed, advocates themselves often present excerpts from the Mayo Clinic and *The Merck Manual* where this supports and benefits their client's case.

In the event that generic medical information is inadvertently omitted from the Board's Statement of Case, as was the case here, the Court's decision in *Deschênes* tells us that it is still necessary to ensure that all of the medical and causal issues in the case are properly identified and that the appellant is given a chance to address them in his or her submissions. The proper way to proceed in such a case is to provide the generic medical information to the advocate as soon as its omission from the Statement of Case is noted and to give the advocate time to fully consider the medical information to make submissions based on it, if it raises any issues that the advocate has not already addressed in their submissions.

Procedural Fairness

The Advocate objected to the Panel's consideration of the Mayo Clinic article as part of the information to be taken into account in its decision, on the basis that this was a breach of procedural fairness.

The case of *Baker v. Canada (Minister of Citizenship and Immigration)*, [1999] 2 S.C.R. 817 outlines the relevant principles that are to be considered when determining whether basic procedural fairness has been denied. The "Baker Factors" as they are now well known, are:

1. Whether there is a duty of procedural fairness.
2. The nature of the statutory scheme.
3. The importance to the individual(s) affected by the decision.
4. The legitimate expectations of the person challenging the decision.
5. Whether procedures employed by the decision-maker adequately address the duty and are appropriate in the circumstances.

There is no doubt that the Board must observe principles of procedural fairness as part of its hearings. The Board must therefore allow the Appellant an opportunity to make submissions on any issues that are relevant to the case prior to making a decision, especially where the issues may be prejudicial to their case.

The Panel therefore agrees that in the present situation, it would be a breach of procedural fairness if the Panel did not allow the Advocate a reasonable opportunity to review generic medical information and to decide whether she would like to add something further to her submissions on the case, before it makes its decision. The Panel rejects the Advocate's suggestion that the Board is precluded from considering generic medical information or other information unless the information itself is reproduced and included in the Board's pre-hearing package. It is sufficient that the Panel draws the Advocate's attention to the issues raised by the information and allows the Advocate an opportunity to make arguments on those issues.

D*eschênes* does not create a "loophole" that prevents the Board from considering generic medical information in the event that a chapter or article containing generic medical information was

inadvertently omitted from the pre-hearing case package or information provided to an appellant before the hearing. In *Deschênes*, the Court was very clear that the Board is permitted to consult and consider external resources in its decisions. However, the appellant should be given a chance to respond to any new issues that are raised by consulting the external resource, particularly if it could be contrary to the appellant's case.

The generic medical information to which the Advocate objects in this case concerns the basic etiology and causes of the claimed condition of OSA. It is the type of information that an advocate or representative would presumably have reviewed when preparing for the hearing, whether or not that information was provided by the Board. Given that the Board's cases involve medical issues, the Board expects that all advocates appearing before it are fully informed as to the basic medical issues that are raised in review and appeal hearings. This is especially so in an entitlement appeal, where the decision under appeal directly concerns the issue of whether military service caused the claimed condition. The causes of OSA, and more specifically whether OSA could be linked to military service, would be the key substantive issues in this case, regardless of whether any generic medical information appeared in the pre-hearing case package.

On the issue of procedural fairness, the Board fully recognizes that: (1) it owes a duty of procedural fairness to the Appellant; (2) it is able to provide this fairness adequately through its statutory scheme; (3) the decisions it makes are of great importance to Appellants; and (5) the procedures the Panel has chosen in this case strike an appropriate balance that allows the Appellant to fully address all of the background information on which the Panel will be basing its decision.

As to the fourth factor, the legitimate expectations of the Appellant, the Panel will simply say that the most legitimate expectation of any person challenging a lower decision would be that the appeal body have as much information and evidence before it as is reasonably possible to fairly determine the outcome of the case. Proceeding in an evidentiary vacuum, knowing relevant additional information is available but disregarding it, is not a "legitimate" expectation under *Baker*, as the Panel sees it.

The Board will consider the generic medical information along with the other evidence in the case when making its decision. Since the Advocate did not receive the generic medical information on OSA prior to the hearing due to the Board's omission of this information from the Statement of Case, it was a fair and proportionate response to adjourn the hearing so that the Advocate could have additional time to review the generic medical information and to prepare submissions, if she so wished.

Section 40, *Veterans Review and Appeal Board Act*

The section reads:

> 40. All proceedings before the Board shall be dealt with as informally and expeditiously as the circumstances and considerations of fairness permit.

The Advocate intervened and declared that the Panel, if it provided for additional time for the purposes of the consideration of the Mayo Clinic article, would be in violation of section 40.

At the hearing, the Panel indicated to the Advocate that it was well-positioned to determine for itself how best to observe section 40. The Board, as master of its own process, must determine how to best balance fairness, expeditiousness and informality in its hearing processes.

As the Supreme Court has concluded in *Baker*, and in numerous cases before and after *Baker*, tribunals have flexibility in creating or adopting procedures that best allows them to deliver procedural fairness in their hearing processes. The procedures used by the Board to achieve fairness will depend on the context and the circumstances of the case but the goal for the Board under section 40 of the *Veterans Review and Appeal Board Act* is to adopt procedures that are both fair, expeditious and informal. To the extent that there is any inherent tension in section 40 between the interests of fairness, expeditiousness and informality, the proper way to resolve that tension is not to completely sacrifice the interests of fairness. Rather, the various interests in section 40 of the *Veterans Review and Appeal Board Act* must be balanced.

There are various aspects to fairness to be considered. On one hand, there must be fairness in the individual sense in that each case should be adjudicated on its individual facts and merits. There is another aspect to fairness as well in that applicants and appellants are entitled to be treated fairly,

consistently and equally to others who are in similar situations or who have had similar issues heard before the Board.

Put more plainly, fairness requires that the Board have a sufficient level of medical information before it in each case to make a well-informed, well-reasoned and rational findings on the medical issues raised by the claim. However, because the Board's non-adversarial hearing model means that no party is responsible for providing or adducing objective or basic degrees of generic information on the medical issues raised in the case, the Board has found it necessary to include generic medical information with its Statement of Case in certain cases where there is no such information in the file, in the Departmental Entitlement Eligibility Guidelines or Departmental Medical Guidelines. The inclusion of generic medical information in the Statement of Case is a procedural innovation that promotes transparency and facilitates the identification of key issues in the hearing for the benefit of panels, applicants, appellants and their representatives by ensuring that they all have access to the same basic level of generic medical information on the claimed condition or disability.

The inclusion of generic medical information in the Statement of Case is one way that the Board has tried to create a process that satisfies the interests of fairness in an expeditious and informal manner in accordance with section 40 of the *Veterans Review and Appeal Board Act*. However, the production of relevant generic medical information at the hearing will also conform with the requirements of section 40, if the procedure is adjusted so as to provide the Advocate with an opportunity to respond to any issues that are raised by the medical information, as is the case here.

Implications of the Non-Adversarial Hearing Process

The Advocate asserted at the hearing that the Board's reference to and inclusion of information, such as the Mayo Clinic article, could appear to place the Board in an adversarial role. The Panel finds it necessary to address the legal issues raised by this assertion.

The Board is an inquisitorial tribunal as per section 14 of the *Veterans Review and Appeal Board Act*:

> 14. The Board and each member have, with respect to the carrying out of the Board's duties and functions under this Act, all the powers of a commissioner appointed under Part I of the *Inquiries Act*.

The Board's proceedings are non-adversarial and inquisitorial in that there is no party opposing the claim. At the Board's hearings, the applicant, appellant, or their representatives make submissions to the Board to highlight the facts and issues which tend to be favourable to their case. However, the Minister is not present to clarify any of the issues that may arise from the first-level decision, or to respond to arguments put forward by an applicant or appellant at the Board's hearing.

The significance of this is that the full proof and argument that are present in the adversarial process are not present under the Board's inquisitorial hearing model. It therefore falls upon Board members, who are accountable for making a sound and evidence-based decision, to probe and assess the merits of the claim and to ensure that all relevant facts and issues are fully clarified before they make their decision.

The Panel notes that it is well settled that an inquisitorial tribunal is to probe the facts of a case. In *Benitez v. Canada (Minister of Citizenship and Immigration)*, 2006 F.C. 461, Mosley J. wrote:

> [98] In my view, the conclusion that the process was intended by Parliament to be inquisitorial rather than adversarial in nature is supported on the face of the legislation. Notwithstanding Professor Galloway's evidence and the Court's awareness of egregious examples of hostile and aggressive questioning, I am not persuaded that a failure to respect that intent by RPOs or Board members in individual cases establishes that the hearings are adversarial. The process was not designed to be a contest between parties adverse in interest but rather an inquiry into whether a claim to Canada's protection is being legitimately made. In that context, a close examination of the merits of the claim is consistent with the nature of the process and the roles of the member and the RPO.

While it may appear to an unsophisticated claimant that a panel's somewhat probing questions at a hearing take on an adversarial hue, the distinction should be easily apparent to experienced members of the Bar.

In any event, the Panel simply presented the Advocate with the medical consensus on OSA as it is described in a well-regarded source and expands more fully on the reference to "medical literature" that appeared in the Minister's decision. The Panel does not accept that the generic medical information introduced any truly "new" issues, or issues which would be unfamiliar to the Advocate prior to the hearing. In fact, the Mayo Clinic material indicates that obesity and being overweight is the primary risk factor for OSA. Obesity is also the main basis of the arguments made in this consequential claim by the Advocate on the Appellant's behalf. The introduction of the Mayo Clinic material confirmed the known causes of OSA and did not raise any new or controversial issue.

When the hearing resumed with the Advocate's additional submissions on the Mayo Clinic article, she acknowledged ". . . the article . . . does not constitute contradictory evidence to that on which the appellant relies."

Summary

The Panel hopes the above comments will serve to fully address the objections raised by the Advocate. The Panel also hopes the above comments will explain the Board's position on issues of procedural fairness and on the appropriate process to be used when a Panel is providing notification at the hearing of generic medical information which it finds to be relevant to the issues in a case.

The merits - Obstructive Sleep Apnea

As the Panel sees it, the following questions must be answered:

1. Which of the known causes of or contributors to obstructive sleep apnea are relevant in the case of the Appellant?
2. Of those relevant causes, are any of them directly related to his already-pensioned rheumatoid arthritis?
3. If so, to what degree, in fifths (1/5 to 5/5) is the appropriate reflection of that relationship for the purposes of a disability award under section 46 of the *Canadian Forces Member and Veterans Re-establishment and Compensation Act*?

As to the first question, and referencing the Mayo Clinic article, the Panel notes the following risk factors appear to be clearly established in the medical profile and history of the Appellant:

- Being overweight (the main basis of claim for this appeal)
- Having a large neck (page 36, report of Drs. Karani/Rebello)
- Having a narrow airway (page 36, comments of the anesthesiologist)
- Having hypertension (controlled, page 36, report of Drs. Karani/Rebello)
- Being male
- Using alcohol, sedatives, or tranquillizers (page 37, report of Drs. Karani/Rebello)
- Smoking (over 50 pack years, quit circa 2000, page 36, report of Drs. Karani/Rebello)

Of the risk factors listed above, only being overweight is claimed, through its linkage to his pensioned rheumatoid arthritis.

On the second question, the Review Panel accepted that the Appellant's weight was responsible for his sleep apnea, and in fact the Department's medical advisor also concluded favourably on the relationship. This Panel has no issue with the linkage between the OSA and the weight gain.

This case turns, rather, on the connection between his weight gain and the arthritis.

The Review Panel concluded the linkage was not direct, in that the Appellant did not appear to have taken all appropriate steps to control his weight using modalities other than the specific types of exercise he was unable to do due to his arthritis. The Review Panel also pointed out the admitted lack of motivation on the part of the Appellant to attempt other forms of exercise, such as swimming; as well as controlling his caloric intake through dieting.

Due to the multifactorial nature of the Appellant's obesity, the Review Panel was unable to see a clear and meaningful pathway between his pensioned arthritis and his sleep apnea.

This Panel has considered the new letter of Dr. Pacis, as well as all of the material that was already in the file. In her main conclusion Dr. Pacis writes as follows (EA-W1):

> In my opinion, the Appellant's OSA is likely a multifactorial causes: His aggravation of his OBESITY is due to lack of mobility due to swelling and pain of the knees, as well as stiffness due to inflammatory arthritis and secondary osteoarthritis. His diet choices and portions. His "lack of motivation" as he claims, is perhaps a sign of fatigue from both the RA and or Depression. His medication for depression is also a factor to be considered. In general, anti depressants can cause weight gain especially for patients who are sedentary from any cause. In his case, immobility from knee joint swelling/stiffness/pain.
>
> In conclusion, the Appellant's RA with secodary severe OA with inability to pursue an active life and to keep a daily exercise regimen is an aggravating if not the cause of his OSA, for the most part. His lack of energy and fatigue due to depression, RA, and the weight gain from his antideppressant, Venlafaxine, also play a role. [As transcribed]

Although the doctor attempts to draw a direct connection between the Appellant's OSA and his arthritis (at least in part), it is this Panel's conclusion that a direct linkage through these many channels of causation has not been credibly made. In the view of the Panel, the main problem afflicting the Appellant's OSA is his weight, however his overweight state has not yet credibly been directly connected with his RA. The doctor did not discuss the important issue of the Appellant's history.

The Appellant was found to be gaining weight and advised to lose 10 pounds at the time of his enrolment in 1989. This was long before the diagnosis of RA. Later, while still in the military, his weight continued to increase – and at a time when he was presumably more active. His weight rose, prior to his diagnosis with RA and prior to any recorded concern with sleep apnea.

As is commonly known, body weight is directly influenced by the ratio of caloric intake versus the degree of caloric consumption through exercise and other everyday movements and activities. There are also other possible causes of weight gain rooted in metabolic, endocrine, and other body systems. To the Panel's knowledge none of these issues have been investigated, and the weight gain is claimed to be caused by RA and osteoarthritis of the Appellant's left knee.

With such a constellation of possible contributors to the Appellant's obesity, and so many contributors to his sleep apnea, the thread is simply too thin to provide a reasonable linkage from his newly-claimed disability directly to his rheumatoid arthritis.

A full medical evaluation of the Appellant's weight is required, including all of the elements that reasonably have contributed to it. Such an evaluation would have to acknowledge that as far back as his 1981 re-enrolment examination [P20] the Appellant's Body Mass Index was a 27, which is in the "overweight" category. He was also remarked as "overweight" in 1986 [BMI over 30, P24-25], yet he was not diagnosed with RA until many years later, in 1998.

The Panel concludes the Appellant – in order to satisfy the requirement for a linkage as claimed – would require an award of entitlement for obesity, either as a consequence of his RA or some other pensioned disability; or in the alternative, because of his Regular Force service. Only then could a reasonable decision be made that addresses all of his OSA risk factors in a proportionate way.

Accordingly, the third question need not be answered at this time, and the decision of the Review Panel is determined to be reasonable and correct, based on the evidence.

DECISION

For the reasons above, the Entitlement Review Panel decision dated 17 August 2011 is affirmed.

Applicable Statutes:

Canadian Forces Members and Veterans Re-establishment and Compensation Act, [S.C. 2005, c.21.]

> Section 45
> Section 46

Veterans Review and Appeal Board Act, [S.C. 1987, c. 25, s. 1; R.S.C. 1985, c. 20 (3rd Supp.), s. 1; S.C. 1994-95, c. 18, s. 1; SI/95-108.]

Section 3
Section 25
Section 39

Exhibits:

EA-W1:	a report from Dr. Ruth Pacis dated 3 January 2012
EA-W2:	a letter from the Advocate to Dr. Pacis dated 18 October 2011
EA-W3:	a letter from the Appellant dated 1 December 2011
EA-W4:	an Internet article from www.mayoclinic.com entitled “Obstructive sleep apnea” (information provided by the Appeal Panel at the hearing on 5 July 2012)

Date Modified: 2013-05-09