Docket: 2008-1581(IT)I

BETWEEN:

RICHARD FONTAINE,

Appellant,

and

HER MAJESTY THE QUEEN,

Respondent.

[OFFICIAL ENGLISH TRANSLATION]

Appeals heard on November 25, 2008, at Montréal, Quebec

Before: The Honourable Justice Pierre Archambault

Appearances:

Agents for the appellant:	Sabrina Guillot Minh-Xuan Nguyen
Counsel for the respondent:	Anne Poirier

JUDGMENT

In accordance with the attached reasons for judgment, the appeal from the assessment made under the *Income Tax Act* (the Act) for the 2005 taxation year is quashed, and the appeal from the assessment made under the Act for the 2006 taxation year is dismissed.

Signed at Boca Raton, Florida, this 29th day of April 2009.

"Pierre Archambault"

Archambault J.

Translation certified true
On this 29th day of July 2009
Monica Chamberlain, Reviser

Citation: 2009 TCC 162
Date: 20090429
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REASONS FOR JUDGMENT

Archambault J.

[1] Richard Fontaine is appealing from assessments made by the Minister of National Revenue (the Minister) in respect of the 2005 and 2006 taxation years. For both years, the Minister disallowed Mr. Fontaine's claim for the tax credit for mental or physical impairment. There is also a limitation period issue for the 2005 taxation year, specifically, whether the Court has jurisdiction to entertain the appeal in view of the fact that Mr. Fontaine did not file his notice of appeal within the time allotted by the *Income Tax Act* (the Act).

Facts

[2] Mr. Fontaine's agent admitted to all the facts set out in paragraphs 5 through 10 of the Reply to the Notice of Appeal, with the exception of those set out in subparagraphs 10(d) and 10(e). The admitted facts are as follows:

[TRANSLATION]

5. Upon assessing the appellant on May 11, 2006, for the 2005 taxation year, and June 7, 2007, for the 2006 taxation year, the Minister of National Revenue (the Minister) disallowed the income tax credit for severe and prolonged physical impairment claimed by the appellant.

6. On or about June 21, 2006, the appellant served a notice of objection on the Minister against the May 11, 2006, assessment, in connection with the 2005 taxation year.

7. On or about June 14, 2007, the appellant served a notice of objection on the Minister against the June 7, 2007, assessment, in connection with the 2006 taxation year.

8. On February 14, 2007, the Minister confirmed the notice of assessment of May 11, 2006, concerning the 2005 taxation year.

9. On March 31, 2008, the Minister confirmed the notice of assessment of June 7, 2007, concerning the 2006 taxation year.

10. In making and confirming the assessments in respect of the 2005 and 2006 taxation years, the Minister relied on the same assumptions of fact, namely:

    (a) Upon filing his income tax returns for the 2005 and 2006 years, the appellant claimed the tax credit for severe and prolonged physical impairment.

    (b) The appellant has been suffering from headaches since 2001.

    (c) The appellant stopped working on April 22, 2002, due to his medical problems.

[3] Mr. Fontaine's testimony and the numerous documents adduced in evidence have established the other relevant facts of this appeal. Some of those facts will only be referred to in my analysis. It would now be appropriate to address the preliminary issue of the Court's jurisdiction with respect to the 2005 taxation year.

The Court's jurisdiction

[4] The notice of assessment for the year 2005 was confirmed on February 14, 2007. The Notice of Appeal was filed in this Court on April 21, 2008, beyond the 90-day period contemplated in section 169 of the Act.

[5] There was no application for an extension of time under section 167 of the Act. The time for making such an application expired in mid-May 2008 under the terms of paragraph 167(5)(*a*) of the Act:

> 167. (5) No order shall be made under this section unless
>
> > (a) the application is made within one year after the expiration of the time limited by section 169 for appealing;
>
> [Emphasis added.]

[6] Consequently, it was too late to make an application for an extension of time at the hearing of November 25, 2008. The argument raised by Mr. Fontaine's agent is that the Notice of Appeal should be considered an application for an extension. The Notice of Appeal that was filed was based on the template provided by the Court on its website. It does not contain an application for an extension; the contents are limited to the notice of appeal, the grounds of the appeal, and a request to waive a $100 filing fee. Mr. Fontaine testified that it was only when he was preparing for his trial with the help of Université Laval law students that he learned of the problem of the Court's jurisdiction and was made aware that his Notice of Appeal for 2005 was not timely filed.

[7] The Court cannot intervene under these circumstances because the wording of paragraph 167(5)(*a*) of the Act is clear. This finding is in keeping with the decision of the Federal Court of Appeal in *Minuteman Press of Canada Company Limited v. M.N.R.*, 88 DTC 6278. The appeal in respect of the 2005 year must therefore be quashed on the basis that this Court lacks jurisdiction.

Entitlement to the credit

[8] Though the issue of the disallowance of the tax credit for mental or physical impairment can only be considered insofar as it pertains to the 2006 taxation year,

I will go over certain facts that arose in 2005. I should also specify that even if this Court had jurisdiction to hear the appeal concerning the year 2005, it would have made no difference for Mr. Fontaine, because he has not satisfied this Court that all the requisite conditions of his entitlement to the credit for 2005 and 2006 were met.

[9] I found the expert report (Exhibit I-1) of Dr. Roy, a neurologist, very instructive. The report was prepared for the Régie des rentes du Québec on January 6, 2005, following an examination of Mr. Fontaine on January 3, 2005. The examination lasted an hour and a half.

[10] The relevant parts of the report read:

> [TRANSLATION]
>
> ***HISTORY***
>
> The patient is 48 years old. He worked as a cashier for the Secur company. He stopped working on June 27, 2003.
>
> The patient has been seen regularly by Dr. L. Durcan, a neurologist, since April 22, 2002.

During his initial assessment on April 22, 2002, Dr. Durcan noted that, since April 2001, the patient had been experiencing recurrent right unilateral headaches associated with intense lacrimation of the right eye; he noted that the patient had daily, almost continuous headaches with some improvement on Verapamil 120 mg three times daily. He stated that the patient was often awakened at night by the headaches, that each headache episode lasted one to two hours, and that there was no associated nausea or photophobia. He stated that the patient ceased working due to the headaches, and that he was also complaining of a generalized feeling of weakness. He stated that a brain MRI in March 2002 was normal, and that the patient underwent a psychiatric assessment in January 2002, at which time no affective disorders were noted. Dr. Durcan's clinical examination was normal in every respect. Based on his assessment, Dr. Durcan diagnosed the patient with cluster-type headache. His recommended treatment was a trial of Indocid 25 mg twice daily in the event that the headache was a continuous unilateral headache. He added that he saw no explanation for the feeling of weakness reported by the patient. He also recommended that the treatment with Verapamil continue.

The patient continued to be seen by Dr. Durcan, mostly at one-month intervals.

Over time, various symptomatic and prophylactic medications were used.

. . .

Commencing in October 2002, oxygen was used during acute episodes.

. . .

The various treatment measures that were utilized did not result in any sustained or significant improvement in the symptoms; there was sometimes a partial or temporary improvement, and this even enabled the patient to return to work from February to June 2003.

The duration of the headaches gradually increased and, as a result, Dr. Durcan changed the diagnosis to atypical autonomic headaches.

An EMG performed on July 31, 2003, did not suggest any evidence of carpal tunnel.

A brain CT scan on August 20, 2003, was normal.

A hepatic workup on May 2, 2003 was normal, and follow-up blood studies on October 2, 2002, showed elevated ALT and GGT. Total cholesterol was 8.04.

. . .

Throughout the patient's evolution, Dr. Durcan always stated that his clinical examinations were normal in every respect; at no time did he witness any signs of autonomic dysfunction or see the patient during an acute attack.

On September 13, 2004, Dr. Durcan submitted a medical report to the Régie des rentes du Québec, in which he stated that the patient had been having recurrent headaches with autonomic manifestations three times daily and that each such headache was three to four hours in duration. He stated that the neurological examination was normal, that the patient's hepatic enzymes had increased and that he was being followed by gastroenterology for that issue. He stated that the paraclinical investigation was negative and that it included a CT scan, an MRI and an EEG. His diagnosis was atypical autonomic headache. He stated that the patient was taking Keppra 500 mg twice daily as treatment. He stated that the patient was able to drive his car.

He recommended that the patient stop working, due to his 10 to 14 hours of debilitating pain per day. He stated that the patient might eventually be able to return to his usual employment, noting that several kinds of headache problems resolve spontaneously but that, in this patient's particular case, there was no response to intensive treatment. He added that, in his opinion, the patient would be unable to perform another job because his headache problem had persisted and therefore prevented him from doing any other work of any kind. He also stated that he had attempted all possible treatments, and that all therapeutic measures had failed.

. . .

LIFESTYLE

The patient stopped smoking in February 2001. He does not drink alcohol.

. . .

SOCIAL HISTORY

Immediately before ceasing employment on June 27, 2003, the patient had worked as a cashier for Secur. He had held this employment since 1985, though he reports a first interruption of work due to headaches from October 2001 to April 2003, and a return to work from April 2003 to June 2003.

At the time he began working for Secur, the patient was also working as a driving instructor.

The patient told us that he had also worked as a taxi driver, and as a cleaner at Hôpital Saint-Luc (1979-1982) and Hôpital Pierre-Boucher (1982).

Prior to this, he had worked in a factory shipping department and for a vending machine business (1977).

The patient has a Secondary V education (accounting clerk program) and took a one-semester driving instructor course at a CEGEP.

The patient lives with his spouse. His son has left the family home.

The patient is currently receiving long-term disability benefits.

SUBJECTIVE EXAMINATION

The patient was seen on his own. He got to his appointment on his own by driving his car from his home in St-Lin des Laurentides.

The patient states that he continues to be under Dr. L. Durcan's care; the most recent visit was on November 13, 2004, and the next appointment is scheduled for January 17, 2005.

He continues to see his family physician, Dr. L. Villeneuve.

. . .

The patient says that the headaches in his right hemicranial region, more specifically in the right periorbital region, began gradually in April 2001. In addition to pain in the periphery of his right eye, the patient complains of pain in the right paramedian region at the vertex.

Shortly after the onset of his headaches in April 2001, the patient noticed that the headaches were associated with lacrimation in his right eye and dripping from his right nostril.

The patient complains of constant and persistent pain around the right eye, which he assesses as 2 to 3/10. He also has persistent pain in the right paramedian region at the vertex; against this backdrop of pain, there are acute episodes which occur two to three times daily, have an intensity of 8 to 9/10, and last two to three hours each. These more acute pain episodes do not tend to occur more frequently at any particular time, and may occur at night during sleep. When his pain is most intense, the patient says that he sometimes experiences nausea; he does not vomit, he sometimes experiences phonophobia, but not really any photophobia. He says that the intense headaches reach their peak in a few seconds, and that he becomes impatient during these paroxysms. He says that his wife reports that he is sometimes puffy and pale during the exacerbations of his headaches. The patient says that, under these circumstances, he sometimes feels right hemifacial swelling, which can even extend a few centimetres into the left side of the face. The patient says that there is no conjunctival hyperhemia in the right eye.

The patient says that the best position for him to adopt during his acute headache attacks is to stand, and he feels the need to pace back and forth in such cases. He absolutely cannot tolerate being in the lying-down position.

The patient has not identified any factor that triggers the headache exacerbations.

The patient says that the frequency of headache peaks has always been the same, i.e. two to three episodes per day, but that, over time, the duration of each of these peaks increased; in addition, the patient says that the various treatment measures were more effective at first, particularly oxygen, which he currently uses for 15 to 20 minutes during each exacerbation with very mitigated success.

During today's interview, the patient reports feeling a right hemicranial headache with an intensity of 5 to 6/10.

The patient tells us that eye, dental and ear check-ups revealed no abnormalities.

He says that he did not obtain any relief with acupuncture or massage therapy.

He reports that taking a Keppra 500 mg tablet mitigates the intensity of his headaches for 60 to 75 minutes.

As far as day-to-day living is concerned, the patient says that he can walk outdoors for roughly 30 minutes once or twice a day; he reports feeling very tired and needing to lie down in a chaise longue upon returning from these walks. He says that he reads the local newspapers, does not watch much television, and can listen to the radio (at a low volume). The patient says that he is too exhausted to maintain his garage entrance. He says that he takes two or three rest breaks for 30 to 40 minutes each but does not fall asleep during those breaks.

The patient says that he lives with his wife, who does not work.

The patient notes that he is able to carry out the activities of daily living independently.

OBJECTIVE EXAMINATION

Blood pressure 120/80. Regular heart rate 108 per minute. Right-handed. Height: 5 feet 5½ inches. Weight: 179 pounds (verified).

The patient entered the examination room at a regular walking pace. There is no limping or wide-based gait. The two upper limbs are in normal balance.

Throughout the interview, the patient remained seated in an upright position, and the movement of his upper limbs and neck was completely normal; the patient did not appear to be experiencing any particular pain or discomfort during the interview. I noted no conjunctival hyperhemia or lacrimation.

There are no abnormalities in cognitive function or language.

Examination of the ocular fundi shows well-delineated pupils and a venous pulse. No photophobia was noted.

The cranial nerves were examined and the confrontation visual field test was normal. Extraocular movements are complete in all directions visual fields are complete on the confrontation. There is no nystagmus or diplopia. The pupils are equal at 5.5 mm and the direct and consensual light reflex is normal. There is no ptosis. Facial sensitivity and motricity are normal. Hearing is normal. Tongue and pharynx motricity are normal.

Examination of the motor system shows equal muscle strength on both sides, in both the upper and lower limbs, proximally and distally. The Barré test is negative. The patient is able to walk on heels and tiptoes.

There is no deficit in the sensory modalities, including touch, pain, temperature, vibration and sense of position. The Romberg test is negative.

The deep tendon reflexes are 1+ bilaterally in the upper limbs and 2+ bilaterally in the lower limbs. The plantar reflexes are in flexion on the right and the left.

Cerebellar examination shows that the patient is able to walk in tandem and perform the finger-nose test without difficulty.

There is no murmur in the carotid artery, the subclavian artery, the eyeballs or skull.

Movement of the neck is unlimited in all directions

There is mild hypersensitivity to pressure on the scalp in the right paramedian region at the vertex. There is no other pain on palpation of the scalp. There is no pain on pressure to the face, in particular around the eyes.

DIAGNOSIS

- Daily chronic headaches (atypical autonomic headaches).

. . .

COMMENTS AND CONCLUSION

Since April 2001, this patient has been experiencing recurring daily headaches which initially had the features of cluster headaches.

Over time, the nature of headaches changed somewhat. They increased in duration and became chronic, persistent and constant. There are two or three more acute exacerbations daily, each lasting a few hours.

The exacerbations that the patient experiences daily retain some features of cluster headaches such as autonomic manifestations (lacrimation and nasal discharge) and a need to get up and pace.

The patient never responded "satisfactorily" to the various treatment measures, which included several symptomatic medications and several prophylactic ones, not to mention periodic treatments with corticosteroids, the use of oxygen, and the use of a sympathetic block.

On a few occasions, the various treatment measures provided the patient with partial and/or temporary relief, but this was never sustained and the patient gradually became refractory to all treatment measures attempted.

The patient has no restrictions in performing the activities of daily living, but his range of domestic activities, such as the upkeep of his home, is restricted. The patient can move about within and outside his home independently, and this includes the use of his personal vehicle.

There is no doubt that the frequency, duration and intensity of the patient's headaches prevent him from performing his previous work as a cashier, or any other gainful employment.

Consequently, based on a detailed review of the various documents in the file, and today's clinical evaluation, we are of the opinion that:

. . .

> **In response to Question #4** regarding the ability to work: As stated in the above discussion, the fact that the patient has two or three acute headaches daily, each of which lasts two or more hours, causes significant functional limitations in his ability to engage in any gainful employment whatsoever. Since the patient has been experiencing these headaches for nearly four years, and they have been refractory to the very numerous treatment measures utilized, it seems likely that the patient's condition will be chronic in nature and unlikely that a spontaneous remission will occur at any point.
>
> [Emphasis added.]

[11] There is also an expert report by Dr. Rousseau, another neurologist, who prepared it for Desjardins Financial Security (Exhibit A-1, tab 13).The report is dated February 2, 2005, and follows a 65-minute examination of the patient on January 27, 2005. Since the report repeats several facts that have already been set out above, I shall only reproduce those that appear to be new, or that corroborate important facts:

> [TRANSLATION]
>
> ***OVERVIEW OF FACTS RELATED TO CURRENT ILLNESS***
>
> . . .
>
> In October 2001, his family doctor, who then believed that he was suffering from depression, ordered him to stop working and referred him for psychiatric treatment. No specific condition was identified.
>
> . . .
>
> Given the persistence of his headaches, he was eventually referred to Dr. Liam Durcan, who first saw him on April 22, 2002, and has been seeing him since. Dr. Durcan performed a complementary work-up, including laboratory tests, an MRI and an EMG. He did not in fact confirm the family doctor's earlier diagnosis of Horton's cephalalgia, but attempted various medications and treatment procedures, none of which were effective beyond the short term. . . .

APPLICANT'S CURRENT CONDITION

Since the spring of 2001, Mr. Fontaine has been reporting daily headaches which he estimates to be 8 to 9/10 in intensity for 16 out of 24 hours, and 3 to 4/10 the rest of the time, despite all the treatments attempted.

He describes right hemicrania in the parietal region, radiating to the occipital region (but never to the neck) and to the right periorbital region. He likens the pain to "being stabbed in the eye with a knife" and his episodes include lacrimation from the right eye, discharge from the right nostril and palpebral ptosis on the same side but without conjunctival redness.

According to Mr. Fontaine, the autonomic phenomena described above may precede the intense pain attacks or occur during them. The pain episodes, which occur up to four times a day, last three to four hours each and may occur at night. During these episodes, Mr. Fontaine uses oxygen or "relaxes". Following these episodes, the pain intensity diminishes to 3 to 4/10.

. . .

The remainder of the neurological questionnaire contributes nothing further, but Mr. Fontaine notes that he tires easily. As far as activities are concerned, he tries to walk two or three times a day. (He has been living in St-Lin des Laurentides for roughly two years.) His wife stopped working a year ago due to fatigue and depression. He takes part in a few household tasks but adds that he does so only to a limited extent because he tires easily. Upon returning from a walk, he must lie down and "nap". He adds that he gets little sleep at night due to the headache attacks. He sometimes does errands and drives his car, but over short distances and, whenever possible, with his wife in the vehicle. In fact, he added that she came with him to my office. He visits friends or his sister, who lives nearby. Snow removal duties are contracted out, and his son or brother-in-law is responsible for maintaining the lawn since he experiences constant nausea. He previously enjoyed fixing things up (antiques) but no longer does.

NEUROLOGICAL EXAM

. . .

Mr. Fontaine was highly cooperative at the interview. He appeared alert, did not seem to be in pain, and exhibited no lacrimation or rhinorrhea.

. . .

INFORMATION FROM MEDICAL SOURCES

Notes of Dr. Liam Durcan

. . .

In a letter to Lise Gauthier dated August 29, 2003, Dr. Durcan states that Mr. Fontaine has been under his care since April 2002. He reiterates the diagnosis of atypical cluster headache (by reason of their duration, frequency and persistence). He reports having attempted several different medications, without much improvement. He provides the list of the various medications used. He adds that he has never seen Mr. Fontaine during an attack, and never observed any autonomic phenomena. However, he adds that Mr. Fontaine did attempt to return to work and that he therefore tends to take Mr. Fontaine's description of his symptoms seriously. He states that, given the frequency and intensity of the pain described, the patient is unable to work and that treatment resources are running out.

. . .

ANSWERS TO QUESTIONS

1. **If you believe that this person's current condition meets this definition (the definition of total disability as worded), please tell us roughly when the person might be able to return to work:**

   The only diagnosis that one can state with certainty in this case is chronic daily headaches, sometimes associated with autonomic manifestations that point to a diagnosis of "cluster" headaches, but certainly atypical.

   . . .

   Indeed, as Dr. Durcan and Dr. Roy have already noted, the prolonged evolution of the head pain presented by Mr. Fontaine for the past years, and the fact that it occurs daily and is refractory to all the therapeutic attempts undertaken, would seem to prevent him from being able to return to his previous employment. Thus, one must conclude that Mr. Fontaine meets the definition of total disability as worded.

2. **If there is a total disability, what are your recommendations as to the treatment required by our insured's condition so that he can resume his activities as quickly as possible:**

   . . .

   At this stage, given the refractory nature of the headaches described by the applicant up to this date, it is far from certain that the current treatment recommendations have a greater chance of success.

[Emphasis added.]

[12] I would also like to mention that Dr. Villeneuve, Mr. Fontaine's family doctor, diagnosed the patient with Horton's headache. In his testimony, Mr. Fontaine also described his headache as Horton's headache. Here is the definition of Horton's vascular headache from Garnier & Delamare, *Dictionnaire des termes de médecine*, 26th ed. (Paris: Maloine, 2000), at page 142: [TRANSLATION]

> Type of facial neuralgia, see this term, typified by paroxysmal burning pain on one side of the head, with an extremely painful sensation of intracranial pulsation, vasomotor disturbances on one side of the face and sometimes the corresponding upper limb, and hyperesthesia when pressure is placed on the branches of the external carotid artery. The attacks occur over and over again during a period of 24 hours or even several weeks. Horton attributed them to a release of histamine.

[13] According to Dr. Rousseau, Dr. Durcan did not confirm Dr. Villeneuve's diagnosis; Dr. Rousseau states this in her expert report. Like Dr. Durcan, Dr. Roy believes that Mr. Fontaine is suffering from atypical autonomic headaches. Dr. Rousseau states that Mr. Fontaine is suffering from [TRANSLATION] "chronic daily headaches . . . that point to a diagnosis of "cluster" headaches, but certainly atypical."

[14] It would be helpful to reproduce certain excerpts on the subject of "cluster headache" from a textbook entitled *The Headaches*, 2d ed., by Jes Olesen, M.D., Peer Tfelt-Hansen, M.D. and K. Michael A. Welch, M.D., dirs.

(Philadelphia: Lippincott Williams & Wilkins, 1999), which can be found at tab 14 of the book of authorities:

CLASSIFICATION AND SHORT DESCRIPTION

. . .

Cluster headache is characterized by attacks of strictly unilateral, severe pain with orbital, supraorbital, or temporal location. Attacks last 15 to 180 minutes and usually occur one or several times per day, especially at night. They are accompanied by ipsilateral conjunctival injection, lacrimation, rhinorrhea or nasal congestion, eyelid edema, miosis, and low grade ptosis. . . .

Two main clinical forms of CH may be diagnosed: *episodic* and *chronic*. The most common form is the episodic form, which affects 80% to 90% of patients. . . .

The chronic form lacks the remissions and is diagnosed after 1 year without remission or if remissions have lasted less than 14 days. . . .

PAIN CHARACTER

The maximum intensity of pain is generally localized behind the eye, radiating toward the temple or to the upper cheek. It is described as excruciating, almost intolerable, as if the eye is pushed out of the orbit or a knife is being turned around. . . . Attacks of kidney stone or intensive tooth ache, which both are examples of locked-in pain processes, resemble cluster headache with respect to pain character and behavior during pain. . . .

CHARACTERISTICS OF INDIVIDUAL ATTACKS

As a function of the cyclical occurrence of the disease, cluster attacks usually have their onset once or twice a day, usually in the same hours in many patients, at least for particular time intervals (1-2 weeks). When plotting the most common hours of onset for the patients described by Manzoni et al. (31), sharp peaks were found between 1 and 2 a.m. and between 1 and 3 p.m., with a third peak reached around 9 p.m. Therefore, the main "entraining" factors of cluster attacks can be considered to be some phases of sleep (REM, in particular) (32) and the time of meals, as well as all the events that occur in the time span considered (activity rest cycle, working hours, and so forth).

In Russell's study (37), 51% of attacks began when patients were asleep, the peak frequency being from 4:00 a.m. to 10:00 a.m. (Fig. 1). The average time asleep per 24 hours for patients during the study did not exceed 6.9 hours, so that the relative

frequency of attacks was increased during sleep. There is also a tendency for daytime attacks to begin during naps or periods of physical activity. It is of interest that Manzoni et al. (31) found an increased frequency of attacks between 1:00 p.m. and 3:00 p.m. However, as they point out, this may be explained by the different living habits of their patients, the majority of whom stopped working during this period.

Pain attacks are typically unilateral, extremely severe, and often accompanied by local ipsilateral symptoms and signs of autonomic dysfunction. [...]

Usually cluster attacks last between 15 minutes and 2 hours, generally being shorter at the beginning and end of each cluster period. According to the diagnostic criteria of the IHS classification, each attack should last not more than 3 hours if untreated. In a prospective study of 77 attacks (37), total duration was less than 30 minutes in 29%, less than 45 minutes in 62%, and less than 1 hour in 78% of patients (Fig. 3). In the same study, the pain reached its peak in less than 10 minutes in almost all cases, maximal pain intensity lasted less than 30 minutes, and the pain subsided in less than 40 minutes. The severity and duration of nocturnal and daytime attacks were similar.

. . .

DIAGNOSIS

Most patients with cluster headache seek medical help between attacks, and it is in fact relatively seldom that the physician has an opportunity to witness an actual attack of headache. With the exception of a possible partial Horner syndrome on the symptomatic side, the results of a physical and neurologic examination are negative. Consequently, the diagnosis is based mainly on the history of the patient. The interview should be performed as soon as possible after an attack and also eventually during an actual attack of headache. If there is only a short history of disease, the diagnosis may be difficult, but if the patient has suffered previously from several identical periods of headache, it is easy to establish a correct diagnosis. Most patients seen at a specialized clinic have had many series of headache attacks and are thus most commonly able to give a detailed and reliable anamnesis.

Some features of the pain of cluster headache are of special diagnostic importance: (a) strict unilaterality, (b) severe intensity, (c) orbital localization, and (d) short duration. [...]

[Emphasis added.]

Analysis

[15] It would be important to quote the text of the relevant provisions of the Act, namely sections 118.3 and 118.4, from the outset:

> Credit for mental or physical impairment
>
> **118.3** (1) Where
>
> > (*a*) an individual has one or more severe and prolonged impairments in physical or mental functions,
> >
> > (*a*.1) the effects of the impairment or impairments are such that the individual's ability to perform more than one basic activity of daily living is significantly restricted where the cumulative effect of those restrictions is equivalent to having a marked restriction in the ability to perform a basic activity of daily living or are such that the individual's ability to perform a basic activity of daily living is markedly restricted or would be markedly restricted but for therapy that
> >
> > > (i) is essential to sustain a vital function of the individual,
> > > (ii) is required to be administered at least three times each week for a total duration averaging not less than 14 hours a week, and
> > > (iii) cannot reasonably be expected to be of significant benefit to persons who are not so impaired,
> >
> > (*a*.2) in the case of an impairment in physical or mental functions the effects of which are such that the individual's ability to perform a single basic activity of daily living is markedly restricted or would be so restricted but for therapy referred to in paragraph (*a.1*), a medical practitioner has certified in prescribed form that the impairment is a severe and prolonged impairment in physical or mental functions the effects of which are such that the individual's ability to perform a basic activity of daily living is markedly restricted or would be markedly restricted, but for therapy referred to in paragraph (a.1), where the medical practitioner is a medical doctor or, in the case of
> >
> > . . .
> >
> > (*a*.3) in the case of one or more impairments in physical or mental functions the effects of which are such that the individual's ability to perform more than one basic activity of daily living is significantly restricted, a medical practitioner has certified in prescribed form that the impairment or impairments are severe and prolonged impairments in physical or mental

functions the effects of which are such that the individual's ability to perform more than one basic activity of daily living is significantly restricted and that the cumulative effect of those restrictions is equivalent to having a marked restriction in the ability to perform a single basic activity of daily living, where the medical practitioner is, in the case of

(i) an impairment with respect to the individual's ability in feeding or dressing themself, or in walking, a medical doctor or an occupational therapist, and

(ii) in the case of any other impairment, a medical doctor,

(*b*) the individual has filed for a taxation year with the Minister the certificate described in paragraph (a.2) or (a.3),

. . .

Additional information

(4) Where a claim under this section or under section 118.8 is made in respect of an individual's impairment

(*a*) if the Minister requests in writing information with respect to the individual's impairment, its effects on the individual and, where applicable, the therapy referred to in paragraph (1)(a.1) that is required to be administered, from any person referred to in subsection (1) or (2) or section 118.8 in connection with such a claim, that person shall provide the information so requested to the Minister in writing; and

(*b*) if the information referred to in paragraph (a) is provided by a person referred to in paragraph (1)(a.2), the information so provided is deemed to be included in a certificate in prescribed form.

Nature of impairment

118.4. (1) For the purposes of subsection 6(16), sections 118.2 and 118.3 and this subsection,

(*a*) an impairment is prolonged where it has lasted, or can reasonably be expected to last, for a continuous period of at least 12 months;

(*b*) an individual's ability to perform a basic activity of daily living is markedly restricted only where all or substantially all of the time, even with therapy and the use of appropriate devices and medication, the individual is

> blind or is unable (or requires an inordinate amount of time) to perform a basic activity of daily living;
>
> (*b*.1) . . .
>
> (*c*) a basic activity of daily living in relation to an individual means
>
> (i) mental functions necessary for everyday life,
> (ii) feeding oneself or dressing oneself,
> (iii) speaking so as to be understood, in a quiet setting, by another person familiar with the individual,
> (iv) hearing so as to understand, in a quiet setting, another person familiar with the individual,
> (v) eliminating (bowel or bladder functions), or
> (vi) walking;
>
> (*c*.1) mental functions necessary for everyday life include
> (i) memory,
> (ii) problem solving, goal-setting and judgement (taken together), and
> (iii) adaptive functioning;
>
> (*d*) for greater certainty, no other activity, including working, housekeeping or a social or recreational activity, shall be considered as a basic activity of daily living;
>
> . . .
>
> [Emphasis added.]

[16] The two sections set out several conditions that must be met in order for an individual to be entitled to the credit. Three are worth our attention. Entitlement to the credit requires (i) a severe and prolonged impairment, (ii) the effects of which are such that the ability to perform a basic activity of daily living is markedly restricted;[1]

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[1] If the impairment does not restrict sufficiently to entitle the individual to the credit, the effects of the restrictions can be combined with respect to more than one basic activity of daily living to determine whether the cumulative effect of those restrictions is equivalent to having a marked restriction in the ability to perform a basic activity of daily living.

and (iii) a certificate of a medical practitioner, or another person specified in the Act, stating that the first two conditions have been met.

[17] It must be emphasized that the position adopted by Associate Chief Judge Bowman (as he then was) in paragraph 18 of the decision in *Morrison v. The Queen*, [1999] 1 C.T.C. 2331, namely, that the wording of paragraph 118.3(1)(*a*.2) in relation to the filing of such as certificate "is directory only, and not mandatory", was rejected by the Federal Court of Appeal in *MacIsaac v. Canada*, [1999] F.C.J. No. 1898 (QL), [2000] 1 C.T.C. 307, 2000 DTC 6020. The Court of Appeal stated: "Section 118.3(1)(a.2) of the *Income Tax Act* is not merely directory. It is mandatory. Simply put, there must be a certificate by the doctor that the individual suffers impairments in the language of these subsections." It is therefore one of the essential conditions precedent to being entitled to the tax credit.

[18] In view of the evidence heard, I acknowledge that Mr. Fontaine had serious health problems which led the Régie des rentes du Québec and his employer's insurer to declare him disabled. This means that they acknowledged that he could no longer work. However, work is not a basic activity of daily living under section 118.4 of the Act. Moreover, I am not satisfied that, during the relevant period, the effects of Mr. Fontaine's disability (his headaches) were such that his ability to perform a basic

activity of daily living was markedly restricted, that is to say, that all or substantially all of the time, he was unable to perform such an activity without requiring an inordinate amount of time. The evidence adduced by Mr. Fontaine does not stand up to a detailed analysis. There are several contradictions in his evidence concerning the three conditions described above.

[19] In his testimony at the hearing, Mr. Fontaine placed considerable emphasis on the effects of the disability on his mental functions and his ability to walk. With respect to his mental functions, he stated that he had many memory problems. He attributes these problems to difficulties with concentration. He says that forgets about things that happened the day before. He says that he cannot go grocery shopping without a list. I believe that he spoke about losing 30-40% of certain details. He even said that he sometimes forgets to turn off the burners of his stove. However, his Notice of Appeal says very little about his mental functions. It states [TRANSLATION]: "I have very sore muscles and my knees lock. Joints are stiff, I no longer have much strength, I am always tired, have intestinal problems, liver problems due to medications, and stomach problems, and fibro gives me irritable bowel . . . I have mental and physical impairments."

[20] I did not see these mental function problems during Mr. Fontaine's testimony. The testimony lasted approximately two and a half hours. The hearing began at 9:50 a.m. and ended at 4:50 p.m. According to my recollection, Mr. Fontaine was present the entire time. I noted nothing abnormal in his behaviour. He was able to answer most questions he was asked. His memory was as good as the average witness who testifies before this Court. He was able to answer the memory-testing questions asked by counsel for the respondent. For example, when she asked him to say when he had a restaurant meal with his accountant, he was able to respond that the meal took place at a Chinese restaurant in Terrebonne at roughly 6:30 p.m. on a Saturday, and that his wife and the accountant's wife were there as well.

[21] It must be added that Mr. Fontaine prepared his own Notice of Appeal for these proceedings. He did not need to retain the services of his accountant friend. He was also the one who went over the conversations that he had with the Minister's representative concerning the disallowance of the disability tax credit for 2005. It is therefore clear that Mr. Fontaine can use his mental functions without much difficulty.

[22] It must be said that many people who are characterized as "normal" have to put up with the memory problems that Mr. Fontaine has described. Many people use

a grocery list to avoid forgetting to make certain purchases. I would add that it is normal to lack concentration when one is in intense pain. It is therefore quite possible that this pain causes Mr. Fontaine to have trouble remembering things that may have happened. However, his attacks are not constant and, as he acknowledged to expert physicians, and as the medical literature that I have quoted discloses, the attacks often occur at night.

[23] Other assertions made by Mr. Fontaine raise doubts about the probative value of his testimony, notably with respect to the alleged lack of cognitive function. Dr. Durcan confirmed that Mr. Fontaine could drive his car. How can one drive a car if one is without cognitive function all or substantially all the time? With regard to this question, Mr. Fontaine stated that he reduced the use of his car considerably, from roughly 15 000 – 20 000 km before his medical problems arose, to roughly 3 000 km afterwards. He said that he only drives close to home – to go to the convenience store, for example – or, as stated in one of his expert reports, to visit friends or relatives. Mr. Fontaine said that when he went to visit his doctor in Montréal, he had someone drive him. However, as Dr. Roy and Dr. Rousseau's expert reports attest, Mr. Fontaine drove from St-Lin to Montréal,[2] a roughly

2 Dr. Roy's office is in the same complex as Dr. Durcan's, on Marlowe Avenue in Montréal.

one-hour trip. He even went alone to see Dr. Roy while he was suffering from a headache with an intensity of 5 or 6/10. His wife came with him to see Dr. Rousseau.

[24] In my view, there is another reason for the substantially reduced use of his car. Mr. Fontaine stopped working after being declared disabled for the purposes of the Régie des rentes du Québec, and his employer's insurance policy with Desjardins Financial Security. Since he was no longer working, he did not have to use a car as often as before.

[25] It should also be noted that no witnesses were called to establish or corroborate the facts presented by Mr. Fontaine. In an appeal, it is dangerous not to adduce the best evidence, such as corroborations through independent third parties. This situation is especially surprising in this instance because the party involved is alleging memory problems.

[26] Another answer given by Mr. Fontaine raises doubts about how frank his responses were. When counsel for the respondent asked him for the name of the accountant who had helped him prepare his income tax returns — Mr. Fontaine had said that he stopped preparing his own income tax returns in 2002 due to his health problems — he replied "Guy". When counsel for the respondent asked him for a last

name, he said he did not recall. He added [TRANSLATION] "Why do you need that answer?", and never provided the accountant's last name. I intervened shortly thereafter, and put it to him that perhaps he wanted to protect his accountant because he thought he had not reported his fee from that work. Mr. Fontaine appeared to acquiesce; in any event, he did not contest this theory. Since he had been using Guy's services for several years, Guy was very likely the person with whom he had dined at the restaurant. It is implausible that he cannot remember the accountant's last name.

[27] Dr. Roy, who examined Mr. Fontaine in January 2005, did not note any significant effects on mental functions or on the other basic activities of daily living, such as walking and dressing oneself. On the contrary, based on Mr. Fontaine's assertions and his own observations, he wrote that Mr. Fontaine [TRANSLATION] "has no restrictions in performing the activities of daily living":

> [TRANSLATION]
>
> . . . He got to his appointment on his own by driving his car from his home in St-Lin des Laurentides). [p. 6]
>
> The patient notes that he is able to carry out the activities of daily living independently.
>
> . . .
>
> There are no abnormalities in cognitive functions or language. [p. 8]
>
> The patient has no restrictions in performing the activities of daily living, but his range of domestic activities, such as the upkeep of his home, is restricted. The patient can move about within and outside his home independently, and this includes the use of his personal vehicle. [pages 10-11]

[Emphasis added.]

[28] Mr. Fontaine's testimony about his walking problems was not convincing either. His explanations concerning the problems that he described strike me as doubtful. In court, he said that it could take him 30 minutes to get to the grocery store, whereas he was able to get there in 10 minutes prior to his medical problems. Let us look at what Dr. Roy and Dr. Rousseau's medical reports disclose. Dr. Roy notes as follows in his report, under the heading [TRANSLATION] "Subjective Examination":

> [TRANSLATION]
>
> As far as day-to-day living is concerned, the patient says that he can walk outdoors for roughly 30 minutes once or twice a day; he reports feeling very tired and needing to lie down in a chaise longue upon returning from these walks. . . . . [page 8]

[Emphasis added.]

[29] The same report contains the following observations from Dr. Roy's objective examination of the patient:

> [TRANSLATION]
>
> The patient entered the examination room at a regular walking pace. There is no limping or wide-based gait. The two upper limbs are in normal balance.
>
> Throughout the interview, the patient remained seated in an upright position, and the movement of his upper limbs and neck was completely normal; the patient did not appear to be experiencing any particular pain or discomfort during the interview. I noted no conjunctival hyperhemia or lacrimation.

[Emphasis added.]

[30] These and other remarks contained in Dr. Roy's report show that Mr. Fontaine did not report any walking problems to Dr. Roy at the beginning of the relevant period. He never said the he had trouble walking a normal distance during his 30-minute walks. It seems to me that such a fact would have been important in establishing disability for the experts at the Régie des rentes du Québec and Desjardins Financial Security.

[31] As for the question of the duration, intensity and recurrence of his headaches, the description that Mr. Fontaine gave in court and the description that he gave the various expert physicians that he met in 2005 differ in many respects, as can be seen from Dr. Roy and Dr. Rousseau's reports and from the comments in Dr. Durcan's file. In court, Mr. Fontaine always assessed the intensity of his headache attacks as 10/10, whereas the intensity that he reported to Dr. Roy or Dr. Rousseau when he met with them was 8 or 9/10.

[32] With respect to the minimum intensity levels, he assessed them at 5 to 6/10 in court, whereas he told Dr. Roy that they were a 2 or 3/10 and told Dr. Rousseau that they were a 3 or 4/10. As to the matter of recurrence, he told the Court and

Dr. Rousseau that he had three or four headaches a day, whereas he told Dr. Roy that he had two or three daily.

[33] With respect to the duration of the attack, Mr. Fontaine told the Court that they were four to five hours long, whereas the duration to which Dr. Roy referred was two or three hours. When Mr. Fontaine saw Dr. Durcan and Dr. Rousseau, he reported that the attacks were three or four hours in duration.

[34] Since he told Dr. Rousseau that there could be up to three or four attacks a day, it was possible that he had intense pain for 16 out of every 24 hours. However, one could also infer that his attacks ranged from four to 16 hours in total, depending on the version that one accepts. He told the Court that he had three or four attacks a day on average, each of which lasted four to five hours, which appears to me to be slightly longer than what he told Dr. Roy and Dr. Rousseau. Obviously, if this were the only problem with Mr. Fontaine's testimony, it might not be sufficient to raise doubts about his credibility. However, when these differing versions are added to the other doubtful elements of his testimony, it leads to the conclusion that his evidence is weak.

[35] Dr. Roy's finding that Mr. Fontaine [TRANSLATION] "has no restrictions in performing the activities of daily living" is consistent with the first of three certificates (Form T2201) which Dr. Durcan prepared and which Mr. Fontaine submitted to the Minister in support of his tax credit claim (Exhibit A-1, tab 8). In the certificate, which is dated February 8, 2006, Dr. Durcan answers "no" to all the questions in Part B (the part which pertains to the restrictions of the basic activities of daily living, and which must be completed by the qualified practitioner). This might appear to be a mistake on Dr. Durcan's part, but that impression dissipates after reading his remarks toward the end: "The patient has intractable headache pain with pain approximately 12 hours per day – this problem is not well described by the categories available on this form." It must be added that he also answered "no" to the question on the last page of the form, which asks whether the impairment has lasted at least 12 continuous months. I consider this to be completely consistent with the other negative answers. The reason that he answered "no" would have to be that he did not feel that that his client's condition came within the description in Part B of the form.

[36] On the other hand, it should be mentioned that Dr. Durcan wrote a "To whom it may concern" letter (Exhibit A-1, tab 12), dated August 14, 2006, in which he

seemed to be trying to revise his February 2006 certificate. However, I would note that this letter is written in general terms. It states, *inter alia*, as follows:

> . . . While not making his activities of daily living impossible, these headaches mean that it takes my patient an excessively long time to perform his activities of daily living.
>
> The headaches have been occurring chronically since 2002 and I suspect they will continue.

[37] Dr. Durcan did not specify the activities to which he was referring. He had the opportunity to correct the situation when he submitted a second certificate dated April 2, 2007 (Exhibit A-1, tab 9, and Exhibit I-3). There, he answered no to all the questions about the restrictions of the basic activities of daily living, except the question about mental functions.[3] His answer to the question, "[W]hen did your patient's marked restriction in the mental functions necessary for everyday life begin?", was "2002". The explanation for his change of opinion is provided on the last page, where Dr. Durcan stated: "During his intense headaches, he is not capable to [*sic*] exercising normal cognitive function and therefore I have made this decision respecting his frequent, episodic [illegible] headaches."

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[3] It must be added that, on this form, Dr. Durcan stated that Mr. Fontaine did not meet the conditions listed under the heading "Cumulative effects of significant restrictions – applies to 2005 and later years".

[38] Unfortunately, this second certificate is incomplete, because Dr. Durcan failed to answer the question on the last page of the form, regarding the duration of the physical impairment.

[39] There was a third certificate, dated September 24, 2007 (Exhibit A-1, tab 10), in which Dr. Durcan changed his answers yet again. This time, in addition to mental functions, he said that Mr. Fontaine's ability to walk and dress himself were markedly restricted basic activities of daily living, and he wrote that, in each case, the impairment commenced in 2002. If this situation existed in 2002, why was it not entered, at least in Dr. Durcan's second certificate?

[40] On the last page of the form, Dr. Durcan provided the following explanation: "Incapaciting [*sic*] and intractable headache pain, 8-10 hours per day during which he cannot perform ADL."

[41] This time, Dr. Durcan completed the duration part properly, because he answered "yes" to the question about duration. However, I would note that he filled out other parts of his certificate incorrectly, as he answered "yes" to the question, "Does your patient meet the conditions for life-sustaining therapy, as described above?" under the heading "Life-sustaining therapy". In response to the request for

details about the therapy, he wrote: [TRANSLATION] "Has used oxygen as treatment (cluster headache)" Yet the section on therapy begins with the statement, "Your patient needs life-sustaining therapy to support a vital function, even if the therapy has alleviated the symptoms . . . ." Oxygen was not being used to keep Mr. Fontaine alive, but solely to enable him to attenuate the intensity of his headaches. Thus, Dr. Durcan misunderstood this section of the form.

[42] The same remarks apply to the section that deals with the cumulative effect of significant restrictions for 2005 and later years.[4] It says, "If your patient is markedly restricted under any of the previous sections, it is not necessary to complete this section." Since he stated, in the previous sections, that his patient was suffering from a markedly restricting disability, Dr. Durcan did not have to fill out the section about cumulative effect. The reason is clear: the last section is about conferring eligibility on a taxpayer who does not meet the other conditions set out in the form.

[43] Lastly, a fourth certificate was submitted in support of a tax credit claim made by Mr. Fontaine. The form was completed by Dr. Villeneuve on January 28, 2008 (Exhibit A-1, tab 11, and Exhibit I-4). In the document, Dr. Villeneuve essentially

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[4] I would point out that the French version of the form itself appears to be deficient: it uses the phrase "*limitations considérables*" whereas the Act refers to "*limitations importantes*". In any event, this is inconsequential here.

certified that Mr. Fontaine was suffering from a mental or physical impairment that markedly restricted his mental functions. He therefore answered "yes" to the question concerning mental functions. Moreover, he indicated "2002" as the beginning of the impairment or restriction.

[44] He did not answer the question about the "walking" activity. However, in the section of the form concerning "Elimination (bowel or bladder functions)", he checked the "Not applicable" box and wrote the remarks [TRANSLATION] "2002 — Horton's cephalalgia" and "2006 — fibromyalgia". I assume that these answers pertain to the section at the beginning of the same page, which deals with the "walking" activity. As for "dressing", Dr. Villeneuve checked the "Not applicable" box, thereby contradicting Dr. Durcan's third certificate.

[45] The section concerning life-sustaining therapy contains mistakes similar to those made by Dr. Durcan. Indeed, Dr. Villeneuve also made the mistake of mentioning oxygen use in this section of the form, even though it was not employed to "sustain a vital function", and the mistake of filling out the section regarding cumulative effects, even though he had stated that Mr. Fontaine's ability to perform a basic activity of daily living was markedly restricted. He also filled out this last section improperly in that he only checked one basic activity of daily living, namely

"walking", when he should have checked at least one other activity in order to comply with the form's instruction: "check at least two of the following".

[46] Since Dr. Villeneuve did not answer the question about walking, and wrote "not applicable" next to the "dressing" activity, it appears that the Minister felt the need to obtain clarifications. Exhibit I-4 is an appendix to the certificate with additional information supplied in connection with the "walking" activity.[5] In response to the question, [TRANSLATION] "Is your patient able to walk (for example, 100 metres) using, as needed, any therapy . . .", Dr. Villeneuve stated "Yes". In response to the question [TRANSLATION] "When your patient is able to walk, does he require an "inordinate amount of time" to do so (even with the help of appropriate therapy, devices and medications?)",[6] Dr. Villeneuve stated "No." Thus, once again, he was contradicting Dr. Durcan's third certificate.

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5 According to paragraph 118.3(4)(*b*) of the Act, the information provided in response to a request for additional information from the Minister in respect of a certificate is deemed to be included in the certificate in prescribed form. Thus, the answers on the questionnaire are part of the certificate form itself.

6 The supplementary information form defines "inordinate amount of time" as follows:

> [TRANSLATION] "To meet the requirement for an 'inordinate amount of time', the activity must take significantly more time than would be taken by an average person who does not have the impairment."

[47] With respect to the "dressing" activity, he stated that his patient could dress himself, and in response to the question whether the patient required an inordinate amount of time to do so, he said that it was not applicable, and then added, after the definition of "inordinate amount of time", [TRANSLATION] "Depends on the pain, which is variable". In response to the question [TRANSLATION] "If so, is this the case all or substantially all the time?" he stated "Yes". I presume that he meant that it was the case when Mr. Fontaine was experiencing very intense pain. However, that did not answer the question whether he had trouble dressing himself all or substantially all the time. It does not appear that he did.

[48] Another answer given by Dr. Villeneuve on the supplementary information form requires comment. On the second-to-last page, he stated that the fibromyalgia began in 2007, not 2006, as he had stated under the heading "Elimination (bladder or bowel function)" on the initial form.

[49] Although I noted no such problems at the hearing, it is possible that Mr. Fontaine now has serious walking problems. However, I have not been convinced that they existed in 2005 and 2006. Fibromyalgia, which appears to have been diagnosed by Dr. Villeneuve in 2007, would more likely account for such

problems than atypical autonomic headache. The following definition of fibromyalgia is from *Stedman's Medical Dictionary*, 28th ed.:

> Fibromyalgia is a disorder of unknown cause characterized by chronic widespread aching and stiffness, involving particularly the neck, shoulders, back, and hips, which is aggravated by use of the affected muscles. The American College of Rheumatology has established diagnostic criteria that include pain on both sides of the body, both above and below the waist, as well as in an axial distribution (cervical, thoracic, lumbar spine, or anterior chest). Additionally, point tenderness must be found in at least 11 of 18 specified sites. Tender points are sharply localized and often bilaterally symmetric. Some points may correspond to sites of pain and others may be painless until palpated. Usually associated fatigue, a sense of weakness or inability to perform certain movements, paresthesia, difficulty sleeping, and headaches are found. About one fourth of patients with fibromyalgia receive partial or total disability compensation. Fibromyalgia frequently occurs in conjunction with migraine headaches, temporomandibular joint dysfunction, irritable bowel syndrome, restless legs syndrome, chronic fatigue, and depression; symptoms are typically exacerbated by emotional stress. The prevalence in the U.S. is estimated at 1-3% of the population, with all races and socioeconomic strata affected about equally. Most patients (90%) are adult women. The onset of symptoms usually occurs before age 50. The disorder is chronic but not progressive. Routine hematologic, serologic, and imaging studies yield uniformly normal results. However, the sleep EEG typically shows intrusions of alpha waves into non-REM sleep and infrequent progression to stage 3 and stage 4 sleep. One third of patients with fibromyalgia have low insulinlike growth factor (IGF) levels. Elevation of cerebrospinal fluid substance P, depression of cortisol production, and orthostatic hypotension have also been reported. Most patients experience moderate to severe disability, but symptoms can usually be mitigated by treatment. Effective treatment programs include education, a regular program of low-impact aerobic exercise, and physical therapy as needed. Cognitive therapy and group therapy are often helpful. About one third of patients respond to pharmacologic agents such as antidepressants (amitriptyline, fluoxetine) and muscle relaxants (cyclobenzaprine).

[50] If problems with walking or dressing existed, it seems to me more plausible that they appeared during a time frame subsequent to the relevant period.

[51] Generally, the analysis of the four certificates discloses contradictions between them, and numerous mistakes in the information provided, which show a lack of attention on the part of the physicians who prepared the certificates. Associate Chief Judge Bowman wrote as follows in *Morrison v. The Queen*, [2000] T.C.J. No. 302 (QL), at paragraph 20:

> . . . Having heard dozens of these cases I have found that such certificates are often unreliable, contradictory or confusing. Some medical practitioners are sloppy in what they write, and a few seem to regard a request by a patient as a nuisance. . . .
>
> [Emphasis added.]

[52] In light of my remarks about Mr. Fontaine's testimony and Dr. Roy's report, which concluded, based on the information provided by Mr. Fontaine, that he could perform his basic activities of daily living independently and that Mr. Fontaine "has no restrictions in the performance of the activities of daily living", I accord no weight to Dr. Durcan's second and third certificates nor to Dr. Villeneuve's certificate. I have not been satisfied that Dr. Durcan's last two certificates describe the true situation with Mr. Fontaine's condition during the relevant period. How can Dr. Durcan assert that the effects of Mr. Fontaine's headaches are such that, "all or substantially all the time", his "ability to perform the mental functions necessary for everyday life" was "markedly restricted" (Exhibit A-1, tab 10, page 10,

paragraph 13), when he declared the patient capable of driving a car? In fact, I believe that Dr. Durcan's first certificate is the correct one; it is the one that reflects reality. His client certainly suffered from an impairment that could have an impact on his ability to perform activities of daily living, but the effects were not of sufficient intensity for one to conclude that it was a marked restriction.

[53] It should also be recalled that Dr. Durcan did not see Mr. Fontaine during an attack. According to Dr. Roy's report, at page 4:

> Throughout the patient's evolution, Dr. Durcan always stated that his clinical examinations were normal in every respect; at no time did he witness any signs of autonomic dysfunction or see the patient during an acute attack.
>
> [Emphasis added.]

[54] Similar comments can be found in Dr. Rousseau's report, at page 7, where she refers to a letter from Dr. Durcan to Lise Gauthier:

> [TRANSLATION]
>
> He adds that he has never seen Mr. Fontaine during an attack, and never observed any autonomic phenomena. However, he adds that Mr. Fontaine did attempt to return to work and that he therefore tends to take Mr. Fontaine's description of his symptoms seriously. He states that, given the frequency and intensity of the pain described, the patient is unable to work and that treatment resources are running out.
>
> [Emphasis added.]

[55] Dr. Roy and Dr. Rousseau were in the same position. Their diagnoses were all based on what Mr. Fontaine told them. According to the medical literature, such a situation is not abnormal. However, the physicians in question had to rely on what

Mr. Fontaine told them in order to diagnose him. For my part, I have noticed that Mr. Fontaine's testimony cannot necessarily be taken completely at face value all the time. He readily exaggerates the significance of certain facts when he describes the symptoms of his attacks, particularly when he describes the impact of his headaches on his mental functions, as we have seen.

[56] In summary, the Court has not been convinced that, during the relevant period, Mr. Fontaine suffered from an impairment (namely atypical autonomic headaches) the effects of which were such that his ability to perform a basic activity of daily living was markedly restricted. Nor has the Court been convinced that there was a significant impairment that caused restrictions the cumulative effects of which would entitle him to the tax credit.

[57] For all these reasons, Mr. Fontaine's appeal for the 2005 taxation year must be quashed, and his appeal concerning the 2006 taxation year must be dismissed.

Signed at Boca Raton, Florida, this 29th day of April 2009.

"Pierre Archambault"

Archambault J.

Translation certified true
On this 29th day of July 2009
Monica Chamberlain, Reviser

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