

Workers' Compensation Appeal Tribunal

Decision # 2

Claim No. 92-1177

Date of Hearing: June 23, 2000

Date of Decision: July 26, 2000

Appeal Committee Members

Presiding Officer:	Heather MacFadgen
Member representative of employers:	Jan Stick
Member representative of workers:	Joseph Radwanski

In attendance: The Worker
Grey Mountain Sound recorded the proceedings.

Location: Boardroom 3B, Elijah Smith Building
300 Main Street, Whitehorse, Yukon Territory

Table of Contents

Introduction	3
Evidence From the Workers' Record	4 – 15
(Paragraphs 1 – 23)	
Evidence and Argument From the Hearing	15 – 18
(Paragraphs 24 – 39)	
Issue	18
Analysis	19 - 21
Conclusion	22

Introduction

The worker appeals the decision of the Workers' Compensation Health and Safety Board ("board") hearing officer dated April 3, 2000. In his decision, the hearing officer upheld the decision of a board adjudicator assessing the worker's permanent partial impairment due to a September 25, 1992 work-related injury as a 40% impairment of the whole person. The adjudicator's decision was made under Board Policy No. 24 "Permanent Physical Impairment" under the authority of section 42 of the *Workers' Compensation Act* ("Act"), RSY 1986, as amended.

On April 1, 2000, the Workers' Compensation Appeal Tribunal came into existence under amendments to the *Act* known as Bill 83. On May 1, 2000 the worker appealed the hearing officer's decision to the new tribunal. The appeal was heard by an appeal committee of the tribunal as established by the tribunal chair under section 18.3(1) of the *Workers' Compensation Act*, 1992 as amended by SY 1999, c.23, s.11. The hearing was held on June 23, 2000 in Room 3B of the Elijah Smith Building.

At the outset of the hearing, the appeal committee determined that it had jurisdiction under section 18.2(a) and 90.(1) (c) of the *Act* to hear the appeal.

The worker appeared personally and gave evidence under oath. No one appeared on behalf of the employer. The proceedings were recorded.

The appeal committee considered all of the worker's record as provided by the board. We also considered Board Policies No. 24, "Permanent Physical Impairment" and GC-07, "Role of the Medical Consultant", also provided by the board as relevant to the matter under appeal according to section 18.3 (4) of the *Act*. Also, prior to the hearing, the worker submitted the following documents to the tribunal for reference in the appeal:

- Excerpts from the *American Medical Association, Guides to the Evaluation of Permanent Impairment*, 4th ed., Chapter 1
- Excerpts from the *American Medical Association, Guides to the Evaluation of Permanent Impairment*, 4th ed., Chapter 2
- Excerpts from the *American Medical Association, Guides to the Evaluation of Permanent Impairment*, 4th ed., Chapter 14
- From the worker's file, a letter from Ginny Gillen, Support Worker, Northern Alberta Brain Injury Society, dated November 15, 1999

In addition, the following documents were marked as Exhibits in the hearing:

Exhibit A: untitled chronology/resume prepared by the worker covering the years from 1980 to 1987.

Exhibit B: Whitehorse Star article dated August 20, 1999.

Lastly, prior to the hearing the tribunal provided the worker with a file summary and tabbed documents relating to the appeal. These were prepared for easy reference to documents from the worker's record during the hearing.

Evidence from the Worker's Record

In order to properly address and understand the issues in this case we think it is necessary to set out a fairly extensive account of the history of this claim as revealed in the worker's record. As part of this account, we will comment on that history. In order to protect the worker's privacy, in any quote or reference to him in a document by name, we have substituted the word "worker" or "he", etc.

- (1) On September 25, 1992, the worker sustained multiple injuries to his head and upper body when he was struck at work by a large post while it was being moved with a loader and chain. Details of the accident were reported to the Yukon Workers' Compensation Health and Safety Board in the Worker's Report of Accident, and the Employer's Report of Accident or Industrial Disease on October 8, 1992.
- (2) Shortly after the accident, the worker was admitted to hospital by ambulance with an admission diagnosis of head injury with loss of consciousness. He was treated by a number of physicians and then followed up by his treating physician, Dr. Wilson. The worker was discharged on October 6, 1992 with a discharge diagnosis of head injury with loss of consciousness, as well as other injuries.
- (3) On November 3, 1992 the board's medical consultant examined the worker, at his request. The medical consultant completed a report on November 5, 1992 which states, in part, the worker "has noted some loss of memory since the accident." Under the section titled "Impression" the report states the worker "did suffer loss of consciousness after the injury. There is no evidence of persisting neurologic defect. . . . I anticipate a full recovery with no permanent impairment of function."
- (4) The worker returned to work with his pre-injury employer on March 29, 1993 in a modified work position. He was laid off in September 1993 (documented by notes to file and worker's letter to the board).
- (5) Initial and ongoing treatment focussed on the worker's back pain and thoracic vertebral injury. On November 30, 1993, the medical consultant determined that this physical injury resulted in a 5% impairment of the whole person. [This award is not the subject of this appeal.]
- (6) In a note dated November 29, 1993 the worker's treating physician states the worker was "feeling tired/seems a bit off today/feeling a bit confused/was working in Swan Hills, Alberta, not labour intensive."
- (7) A note to the worker's file dated April 7, 1994 states that the rehabilitation counsellor contacted the office of Dr. Snyder, a neuropsychologist in Edmonton "regarding a neuropsych assessment. This is in consideration of the fact that the worker did experience LOC [loss of consciousness] in his accident. The possible impact of this has not been addressed to date."

- (8) Dr. Gendemann of the Department of Psychiatry, Faculty of Medicine, University of Alberta assesses the worker on January 19 and March 7, 1994 and reports on May 31, 1994 by letter to Dr. Ramsey. This report states, in part, that the worker “has developed a major psychiatric condition subsequent to the head injuries that he has sustained . . . these will be ongoing difficulties which may certainly compromise his employability because of his mood instability and subsequent cognitive difficulties which he may develop.” [Emphasis added.]
- (9) On April 15, 1994, at the Lyle Gross Rehabilitation Centre, the worker had a Functional Capacity Evaluation (FCE). The report to the board by Michelle Walkin and Dr. Gross on the FCE, dated May 25, 1994 deals primarily with physical capacities but the report notes that the worker “reported that he is very depressed and that this affects his concentration.”
- (10) In a note to the worker’s file dated September 14, 1994, the rehabilitation counsellor states he had contacted Dr. Snyder regarding the delay in receiving his report. It says that Dr. Snyder reports that he is attempting to contact the worker’s mother to obtain further information about a childhood illness.
- (11) Dr. Snyder writes a letter dated September 18, 1994 to the board, with an accompanying report of his neuropsychological assessment of the worker whom he examined and tested on May 27 and June 11 of 1994. Dr. Snyder is a clinical neuropsychologist. His report states in part that the worker “is disabled with reference to motor skill, complex, integrated cerebral function, and emotional regulation. Of these disabilities, that involving motor skills is the least disabling for doing activities of daily living and doing his prior work. His emotional disturbance under the present circumstances of mild-to-moderate stress is of severe degree and consequently **represents an estimated 70 percent impairment of the whole person.** With appropriate treatment and a normalization of stress I would predict a reduction in the degree of emotional disturbance to a mild-to-moderate level (30 – 40% impairment) **depending** on some improvement in complex, integrated cerebral functions. The latter, which in part may be interactively associated with his emotional disturbance, is more prominent than before the 1992 accident and represents a disability which could preclude or limit future employment. With appropriate treatment and improved emotional modulation it is hoped that there will be some gains in complex, integrated cerebral functions, gains which should be documented by re-examination in about two years. At present I would estimate this disability to be of minimal significance with reference to activities of daily living but moderately impairing (40%) with reference to competitive employment at a level he is capable of.” [Emphasis added.]

- (12) In a memorandum dated October 7, 1994 the board's acting Director of Claimant Services recommends that the worker's adjudicator contact Dr. Schmidt to review Dr. Snyder's report and to provide an opinion on the role that the worker's documented alcohol and drug abuse, personality disorder and pre-existing head injury play in the worker's current status.
- (13) In a letter to the worker's adjudicator dated December 12, 1994, Dr. Schmidt, a neuropsychologist, reports on his review of the previous test results and assessments of the worker done in 1989 and 1982 following a head injury due to a motorcycle accident as well as the results of Dr. Snyder's 1994 assessment, the report of Dr. Gendemann, a psychiatrist, and the FCE report of Dr. Gross. Dr. Schmidt did not examine or interview the worker. His report concludes "I find nothing in Dr. Snyder's report that would support the conclusion that the 1992 accident caused or exacerbated [the worker's] problems. I must of course point out that I can likewise not conclude that the 1992 accident did not cause or exacerbate them. However, given the presence of a previous severe head injury as well as ongoing history of psychiatric disorder and substance abuse, in my opinion, the cause of the worker's neurological disorder at this time, to the extent that he has one, cannot be determined on the basis of available test results."
- (14) On December 22, 1994, a rehabilitation counsellor writes a letter to the worker's adjudicator after reviewing the claim file including the report of Dr. Schmidt and Dr. Snyder. Her letter states in part " the problem seems to be that one cannot conclusively rule out that the worker's 1992 accident did not contribute to the neurological deficits that he is currently experiencing."
- (15) As part of a board rehabilitation program, the worker attended several counselling sessions with a local psychologist and her reports to the board are dated March 31, 1996 and December 6, 1996. She states that these sessions were to assess the level of stressors in his life and to develop a treatment plan to improve his level of functioning with specific emphasis on cognitive restructuring. Her March 1996 assessment deals only with his emotional/behavioural state rather than cognitive ability or skills. With respect to the worker's social functioning she states as follows:

The worker lives alone and reports he finds social interaction very stressful. He states he avoids it as much as possible to avoid what he feels is the inevitable judgment of others. Assessment of his social skills has been hampered by his reluctance to allow me to talk to previous co-workers or friends and family. . . . In therapy sessions, he demonstrated difficulty with eye contact. He states that it is challenging for him to process auditory information and maintain visual contact simultaneously. This coping strategy would impact on the comfort level of social interaction considerably. . . .

The worker still experiences distractibility, short term memory problems, reading difficulties and conceptual problem solving deficits due to his head

injury. He reports that it takes him a much longer time to write any information and that it causes him a great deal of anxiety to do so. He also states that it is necessary for him to solve problems in a different way since his injury.

Most of his emotional problems of anxiety and depression typical of closed head injury are managed by Prozac. He is reluctant to use this approach and feels frustrated by his dependence on it.

He displays fairly good insight into most of his personality changes concomitant to his injury. He reports he is suspicious, overly optimistic, impatient, irritable, impulsive, overreacts to events, has verbal outbursts, high distractibility, poor emotional braking, and rigidity in thinking patterns. . . .

He has also experienced complete disorientation and got lost coming to our appointments despite repeated visits

The worker continues to find that his cognitive deficits interfere with his daily functioning. He is demonstrating a limited but realistic coping strategy, typical of individuals who have experienced a closed head injury, avoiding those things he can no longer do with the same level of success. His prior cognitive functioning had given him many satisfactions and he admits his life has been simplified and restricted by his memory problems and inability to maintain good comprehension of complex ideas.

Many social interactions have been severed and he is very isolated socially due to his emotional outbursts and cognitive deficits

Most of his adjustment to his cognitive limitations and personality changes has been done independently and do not reflect adequately the emotional and social supports necessary for full and healthy functioning,

The worker would benefit from continued involvement of WCB's services and programs as he adjusts to the realities of his loss of former skills. This requires extended education and rehabilitation with respect to closed head injuries of this type. [Emphasis added.]

- (16) On May 3, 1999, a board rehabilitation counsellor writes a memorandum to the Director of Claimant Services after reviewing the worker's file. We set out a significant portion of this memo here because it details the lack of timely treatment for the worker's head injury as well as how this lack could have affected the degree of his impairment (in other words, his recovery, as assessed by one of the consultant neuropsychologists). This memo also provides a good summary of the findings of the various consultants who assessed the worker:

The worker received minimal treatment for his head injury until 4 years post-injury likely due to the time involved to investigate and complete the appeal process. . . .

He was assessed by Dr. K. Gendemann, a psychiatrist from the University of Alberta Hospital in Edmonton on January 19 and March 7, 1994.

Dr. Gendemann indicated that his examination and review of information inferred that the worker had developed a major psychiatric condition subsequent to the head injuries he sustained (in 1980 and 1992). He felt that the worker's condition might certainly compromise his employability because of his mood instability and subsequent cognitive difficulties, which may develop. He recommended treatment options and suggested the worker consider alternative work opportunities which would be less stressful physically and psychologically and that would minimize the risk of further CNS [central nervous system] type insults.

The worker completed a neuropsychological assessment on May 27 and June 11, 1994 with Dr. Snyder, a neuropsychological consultant from Edmonton. Aggressive psychotherapy in combination with cognitive rehabilitation, pain management, further psychiatric management, a CT or MRI of the brain was recommended. [Emphasis added and we note that none of these have been done to date.] Dr. Snyder assessed the worker's prognosis for return to work as fair depending on the permanence of his neurobehavioural deficits and the degree of organicity underlying his personality disturbance. Dr. Snyder concluded that the worker's psychological condition was exacerbated by his 1992 head injury. Limitations identified by Dr. Snyder included motor skill, complex, integrated cerebral function and emotional regulation. The worker was assessed as being 70% impaired but with appropriate treatment and a normalization of stress he predicted a reduction in the degree of emotional disturbance to a mild-to-moderate level (30-40%) depending on some improvement in complex, integrated cerebral functions.

The worker's neuropsychological assessment was sent to Dr. Schmidt, a neuropsychology consultant in Vancouver for a second opinion on the cause of the worker's ongoing psychological/psychiatric problems. In a report dated December 12, 1994, Dr. Schmidt notes that differentiation of the cause of a neuropsychological deficit relies primarily upon history. He later reports that his findings are based solely on the review of written documents and that there are large holes in the history at his disposal. Dr. Schmidt concludes that "there is nothing in Dr. Snyder's report that would support the conclusion that the 1992 accident caused or exacerbated the worker's problems. I must of course point out that I cannot conclude that the 1992 accident did not cause or exacerbate them." He goes on to provide his opinion that the objective information cannot determine the cause of the worker's ongoing psychological/psychiatric signs and symptoms and recommended collecting subjective reports from people who knew the worker before and after his 1992 injury and from people who worked with him when he returned to work in the 1983 construction season. Dr. Schmidt did not comment on treatment options.

The worker's entitlement to benefits was not allowed as outlined in a memo from his adjudicator to the Internal Review Committee, dated December 30,

1994. Much weight appears to have been given to Dr Schmidt's report despite the fact that he did not deny the possibility that [the worker's] head injury could have been exacerbated by the 1992 accident. No investigation was done to close the holes in the history suggested by Dr. Schmidt. The worker's limitations and need for treatment outlined by Dr. Snyder and Dr. Gendemann were not accepted. There are no documents on file to suggest he received treatment until the adjudicator's decision to deny benefits was reversed by the Appeal Panel on May 31, 1995. The Appeal Panel ruled that the worker had entitlement to benefits including vocational assistance according to policies CS-02, CS-05 and CS-07.

On October 17, 1995, the worker completed an interview with a vocational counselor from Voc-Aid to review his education, skills and work experience. He also completed an interest test. No aptitude test was completed and little consideration was given to the neuropsychological test results by the vocational counsellor. A rehabilitation plan was developed based on her assessment but not signed by the client until January 8, 1996. The plan focused on completing work conditioning to maximize his functional abilities, functional testing, and cognitive restructuring with local service providers.

In February 1996, the worker completed an eight-week work-conditioning program aimed at maximizing his functional abilities. He was discharged fit to return to work to sedentary and medium level work.

The worker was assessed and treated by . . . a local psychologist regarding his head injury. He had ten appointments between January and July of 1996.

On March 27, 1996, the worker was deemed at his request. He stated that he wanted to get on with his life. At the time, the worker was still undergoing treatment with a psychologist. The worker was deemed capable of working as a soil sampler and a soil technician and was considered to be capable of earning \$41,579.20 per year. He was provided with re-employment assistance while he actively searched for work. There is no record of the worker securing suitable employment. There is no letter from his adjudicator indicating his benefits were stopped. The claims system indicates that he was paid re-employment assistance until June 24, 1996.

Conclusions

Treatment

Dr. Gendemann and Dr. Snyder both stressed that intensive treatment was required in 1994. The worker's treatment for his psychological/psychiatric condition amounted to ten appointments with a local psychologist and some work with the OT [occupational therapist] at the POWER Program 4 years post-injury. The lengthy process of investigation and the appeal process likely caused the delay. The worker's treatment related to his head injury may have been a case of 'too little, too late' to have any real effect. The last report from the local psychologist does not clearly indicate whether treatment was complete in 1996 or if further follow-up was required.

Vocational Rehabilitation Plan

The vocational rehabilitation plan signed in January of 1996 has two major limitations. The plan did not include:

1. The treatment concerns outlined in Dr. Gendemann or Dr. Snyder's reports. He needed further intensive treatment, which was not locally available. He also needed further neuropsychological testing and psychiatric follow-up upon completion of treatment to determine his employability.
2. Any testing for the worker's aptitudes for work or any reference to how his cognitive and emotional limitations affected his employability. According to Policy CS-07, a vocational assessment should include an individual's interests, aptitudes, physical abilities and skills. The worker's aptitudes were not tested nor was any reference given to the neuropsychological test results that had been completed by Dr. Snyder despite the worker's multiple head injuries and complex psychological and psychiatric history.

Deeming

Deeming the worker on March 27, 1996, was inappropriate despite the fact that he had requested it. Neither his family doctor, the medical consultant, nor his psychologist was consulted regarding his fitness for work. In fact, the worker was still undergoing psychological treatment to overcome cognitive limitations and therefore, was not fit for the work identified as suitable. On March 27, 1996 the worker did not meet the criteria for deeming according to policy CS-08.

It does not appear reasonable to have deemed the worker as a soil sampler and soil technician. His education as a civil engineering technologist and computer programmer was completed in the late 1970's, prior to his 1980 head injury. The worker tried to return to school in the early 1980's and was unsuccessful.

Recommendations

I recommend that the worker be referred to a facility that can determine his current physical and psychological status and make recommendations about treatment options and employability. Specialized testing and treatment required is not available in the Yukon and a facility in Alberta or B.C. is recommended. A new vocational rehabilitation plan will be developed in light of the test results. He will be consulted in the development of the plan. The focus of the plan should be on assisting him to secure employment consistent with his physical and psychological status.

[We point out that all the emphasis by underlining in this lengthy quote was added by the appeal committee.]

- (17) On June 23, 1999, the rehabilitation counsellor wrote Dr. Snyder requesting follow-up neuropsychological testing in August, 1999 "to determine if there are any treatment options available to [the worker] and to determine his psychological

abilities and limits related to work. By an August 9, 1999 letter the rehabilitation counsellor also asks Dr. Snyder to answer a number of questions including “what is the worker’s current level of neuropsychological functioning?” This report as well as Dr. Snyder’s report done in 1994 form part of the basis on which the board’s medical consultant and the adjudicator assessed the worker’s permanent partial impairment, which of course is the subject of this appeal.

(18) Dr. Snyder’s August 30, 1999 reporting letter to the board states, in part, as follows:

The worker showed evidence of word finding problems and spoke slowly and disjointedly. . . . He also interpreted some words in unusual ways, giving to them a broader interpretation than was intended. . . . During testing he used subvocalization during reading and a verbal learning task. These types of behaviour suggest problems organizing his thoughts. Other unusual behaviour observed during testing included: no eye contact and putting his head on folded arms on a counter top during a word learning task . . . and low frustration tolerance. . . . He lives alone in a small cabin on land he owns. He said he is uncomfortable to be around other people and generally keeps to himself. His social discomfort in part is associated with a feeling that others are looking at him as if he is “off his rocker”. He carries a small notebook with him to write down important information, including daily activities that he plans each morning. His social discomfort was said to be associated with his failure to make sense of other people’s behaviour. He gave several examples of conflicts he has had with people. These conflicts derived from their failure to do what he had expected. In addition to his interpersonal concerns, he said that his memory is problematic and that he has difficulty with reading. Exemplifying his memory problem was recurrent failure to close a rear door of a motorized work vehicle that has resulted in costly damage to the vehicle. In conversations he said he has to say what comes to mind or else he will forget it. Physically, he is subject to fatigue later in the day and therefore he arranges for his appointments to be in the morning. . . . He did score below normal on two tests of attention (Connors CPT and Stroop Color-Word) and on the majority of tests for memory. He also endorsed symptoms and characteristics consistent with a high level of psychological distress that has not diminished relative to 1994. From a functional standpoint, these results indicate that [the worker] could be expected to have difficulty doing work that requires sustained attention to visual detail, the efficient processing and recall of auditory information, and memory for visuospatial information. Practically speaking, sedentary work on a computer for an extended period of time is probably contraindicated, as is work that would require his attendance at meetings in which he has to rapidly process and retain information presented . . . it is essential to discuss his psychological distress and how this distress may be related to both his capacity to work and the types of work he will be able to realistically manage. . . .

The worker was assessed by Dr. Bornstein two months after sustaining a severe traumatic brain injury in a motorcycle accident [in 1980]. . . . the assessment showed evidence of mild neuropsychological deficits and moderately severe psychological disturbance characterized on the MMPI by social withdrawal, anxiety, and depression. Dr. Bornstein viewed the worker's psychological disturbance as partly reactive to the brain injury and emphasized that this psychological disturbance was the primary obstacle to [his] successful readjustment. . . . Dr. Bornstein reassessed the worker in January 1982, two years post-injury [*Note: two years is incorrect – Jan/82 is only 14 months post-injury*] because of persistent complaints of problems with concentration, as well as discomfort in groups of people. The results of that reassessment showed improvement in motor speed and coordination, psychomotor speed, and performance IQ, improvements expected for someone recovering from a brain injury. . . . In contrast, his mental health and MMPI were not improved and continued to indicate persistent depression, anxiety and social withdrawal. . . .

[We note here that Dr. Snyder then states that he does not know much about the worker's work and social history prior to the accident in 1992.] When I initially assessed the worker in 1994 items on the MMPI indicated that his psychological distress was as great or greater than in 1980 and 1982 when assessed by Dr. Bornstein. . . . All the interventions provided by the [local psychologist] were appropriate and of potential benefit to the worker. Unfortunately, treatment for his most significant impairment, an impairment that is the primary cause of his social problems and contributes to his cognitive difficulties, was not included in the WCB vocational rehabilitation plan. His most significant impairment has been and continues to be a psychiatric disorder that goes beyond an adjustment reaction to the effects of brain injuries on his life. If he is to return to work, his psychiatric disorder will have to be more effectively managed. In my opinion, the primary focus of any vocational plan for him should be his mental health, including his psychiatric disorder. . . .

As for his current levels of neuropsychological functioning, the results of testing showed minimal change of practical significance in comparison to 1994. . . . The practical implication of his memory impairment is that he has limitations on learning new information, including information that would be part of training for a new job or occupation. . . . The interpretation that best fits . . . his complaints of problems with concentration and with simultaneously dealing with multiple sources of information, and the combined test results [presumably the '94 and '99 tests] is that he becomes overwhelmed by a high information load. This interpretation could explain his performance on tests of verbal memory and tests of attention, as well as his discomfort with groups of people and his low frustration tolerance. . . . His concerns about poor reading comprehension are therefore likely secondary to information overload and/or memory deficits. . . . His most debilitating problems involve a psychiatric disturbance that has been evident since at least 1980 and has not abated.

[Emphasis added—we note that later in this decision we take issue with the statement that this condition did not abate between the 1980 and 1992 injuries, based on evidence presented at the hearing.]

- (19) In a memorandum dated September 22, 1999 the adjudicator asks the medical consultant to review the worker's file to determine if he has a permanent partial impairment attributable to his head injury. In this memo, the adjudicator refers to the reports of Dr. Gendemann and Dr. Snyder.
- (20) The medical consultant's report dated September 24, 1999 reiterates Dr. Snyder's conclusion that the worker's most debilitating problems involve a psychiatric disturbance that has been evident since at least 1980 and has not abated. This conclusion is important in terms of the impairment award eventually made because the medical consultant concludes and the adjudicator decides that the impairment cannot be fully attributed to the 1992 accident and there is a deduction of 10% for a pre-existing impairment. We disagree with this conclusion as we will explain in our analysis of the evidence later in this decision.

The medical consultant notes in his report that the Yukon board uses the American Medical Association Guides to the Evaluation of Permanent Impairment, Fourth Edition [the AMA Guide] for assessing levels of permanent impairment. He explains that the fourth edition, unlike the second, does not use percentages for estimates of mental impairment because such percentages are highly subjective as there are no precise measures of impairment in mental disorders. In addition, percentages are likely to be used inflexibly by adjudicators, who then are less likely to take into account the many factors that influence mental and behavioural impairments.

The medical consultant also explains that the AMA Guide sets out 4 areas for the assessment of the severity of mental impairments. They are:

1. limitations in activities of daily living,
2. social functioning,
3. concentration, persistence, and pace, and,
4. deterioration or decompensation in work or work like settings.

The medical consultant also sets out in his report the five classifications of impairments from the AMA Guide. They are:

1. Class 1 – no impairment
2. Class 2 – mild impairment in which the levels are compatible with most useful functioning
3. Class 3 – moderate impairment where the levels are compatible with some but not all useful functioning
4. Class 4 – marked impairment where the condition significantly impedes useful functioning.

5. Class 5 – extreme impairment which precludes useful functioning.

The medical consultant then gives a qualified opinion as to which of the 5 classes he would assign the worker's level of impairment. We say "qualified" because of the conditional language the medical consultant uses: "in reviewing the reports, it appears that the worker may be in Class 3 with moderate impairment of function." [Emphasis added.] In addition, he says that he is "unable to choose a precise impairment estimate" so gives a range which is "not mandated" and "open to interpretation." He also says that "this is an extremely complex area."

In reaching this opinion he appears to consider 3 of the 4 areas (daily living, social functioning, and deterioration in work settings) with respect to the results of the reports/assessments he has reviewed. He says the fact that the reports state that the worker is well groomed, punctual, mentally alert, oriented and physically fit "suggests" that he is able to carry out the activities of daily living and social functioning. However, the medical consultant notes the worker's difficulty in interactions with others and social discomfort and highlights Dr. Snyder's assessment that the worker's "social discomfort, pre-occupied thought process, and vulnerability to stress and information overload preclude most, if not all, types of competitive employment." We note here that the medical consultant did not interview the worker for his report so did not have the benefit of observing him and hearing first hand about the worker's difficulties in daily living and social functioning, as we did in the hearing.

We also note here that preclusion of "most, if not all, types of competitive employment" would fit more closely with Class 4 (significantly impeded functioning) rather than Class 3 (some but not all useful functioning). We note as well that the medical consultant does not mention one of the four areas for assessing the severity of impairment, that is, "concentration, persistence, and pace." Nor does he mention the Dr. Snyder's 1994 estimate of impairment at 70%.

Finally, the medical consultant does comment that there was an impairment before the most recent head injury in 1992 and therefore not all the worker's current impairment can be attributed to the compensable 1992 injury. As we said earlier, we will take issue with this conclusion based on our analysis of evidence presented at the hearing.

- (21) On February 10, 2000 the worker's adjudicator writes a letter regarding the worker's Permanent Partial Impairment Award. She refers extensively to the medical consultant's report and accepts his opinion of a Class 3 impairment signifying moderate impairment of function. She also accepts the medical consultant's estimate of a pre-existing impairment in the mild to moderate impairment category. In addition, she applies what appear to be the ranges in percentages from the second edition of the AMA Guide. The result is an award of 40% permanent partial impairment (by subtracting 10% for pre-existing from 50% for current total partial impairment).

- (22) The worker appealed the adjudicator's February 10, 2000 decision to the board's Internal Review Committee ("IRC").
- (23) A hearing was held on March 23, 2000 before the board's hearing officer (instead of before an IRC, due to changes from Bill 83). The hearing officer's decision of April 3, 2000 confirms the adjudicator's decision of February 10, 2000. The hearing officer states that the board Policy with respect to "Permanent Impairment" has been followed because the AMA Guides were used. He states that there is no requirement for the medical consultant to personally examine the worker as part of the evaluation process. He also states that there is no reason to not accept the medical consultant's opinion "in the absence of evidence of greater weight from another physician." It appears that the worker's argument to the hearing officer -- that Dr. Snyder's testing and assessment of a greater degree of impairment (that is, 70%) should be given more weight because he specializes in neurological impairments -- was rejected because Dr. Snyder is a neuropsychologist not a physician and because the medical consultant has "correctly referred to an opinion of a specialist [the neuropsychologist] for assistance in making an evaluation." The hearing officer does not deal with the point that the neuropsychologist's evaluation of the degree of impairment is different from the medical consultant's: nor does he consider that the medical consultant may have overlooked the neuropsychologist's assessment of a 70% impairment since it is not referred to in the medical consultant's opinion.

Lastly, the hearing officer states that he "is not able to form medical opinion, he or she can only refer to the opinions of medical practitioners and reach a conclusion from that evidence."

Evidence and Argument From the Hearing

Before beginning his evidence and submissions, the worker told the appeal committee that in three month's time, he would be into the 9th year of his compensation claim. He explained that he had requested assistance from the Workers' Advocate for his appeal. The Workers' Advocate's office was willing to represent him but not until sometime next year. The worker said he decided that would be too much of a delay and therefore, he was representing himself.

- (24) The worker says, in his view, the issues of the appeal are:
1. the 10% reduction of the permanent partial impairment award (the "PPI") that was made due to a pre-existing, non-compensable condition -- the worker disagrees that any such deduction is warranted; and
 2. the 50% PPI evaluation made by the adjudicator and confirmed by the hearing officer -- the worker says the percentage is too low. He says the assessment of Dr. Snyder of a 70% PPI should have been given greater weight in the board's determination.

- (25) The worker submits that the handwritten note on the May 3, 1999 memo (see paragraph 16) from a board rehabilitation counselor to the Director of Claimant Services is an admission by the board that the management of his file over the past 8 years has been questionable. This note states:

[To the rehabilitation counselor] - follow up on your plan for assessment of the worker. – discuss this memo with [the adjudicator]. I think she should review the file first and then you can see whether she agrees that past management of this file has been . . . ? Thx, S.

- (26) The worker submits that there is not “well-documented evidence” for the medical consultant’s assertion with respect to a pre-existing condition. The medical consultant states “there is well-documented evidence of mild to moderate disturbance dating back to 1980-2.”
- (27) The worker says that the earliest assessments by Dr. Bornstein were not on his file, although referred to by other specialists. Therefore, he cannot determine if Dr. Bornstein’s assessments of him were based on the AMA Guides. He says that both of this doctor’s assessments of him were within thirteen and a half months of his motorcycle injury in 1980 – the first being two months after his accident.
- (28) The worker referred to Exhibit “A”, a resume of his activities from October 1980 when he had his first head injury in a motorcycle accident. This resume shows a succession of jobs, completion of a two-year computer systems program and a number of successes in a team sport-- competitive curling-- as well as teaching curling, all over a period of seven years from 1981 –87.
- (29) The worker says that his activities over this period show he was able to function quite well. He says the job in 1981 was as a field engineer (which he held for 6 months before recession layoffs) and he was a foreman at the time as well. He says he curled as the “skip” [leader] and that to be successful at this sport requires strategy, critical thinking, planning shots, etc. He says it is a social sport. He says he won the major bonspiel in March 1982, several months after the last assessment by Dr. Bornstein in January 1982. He says his computer program in 1982 involved writing programs, going to college in classrooms, working with other students. He says he taught curling in Yukon high schools from 1985-9 with a curriculum he designed. He says that at the time of his 1992 accident, in his job he was just starting to do “take-offs” for bids and that he was more or less in charge a lot of times. He did survey work and foreman work. He would be in charge of smaller jobs and on a bigger job, he would be in charge of one part of it (e.g., the sub-grade elevations). His work included laying out sewer lines, determining the elevations, setting the grade, doing offsets, etc. He also did some office work.
- (30) The worker points out the long gap in any assessment of his functioning from the last Bornstein assessment (in 1982) to the next assessment by Dr. Snyder in 1994.

The latter was 12 years and 5 months after his first accident and almost two years after his second accident. He says it is wrong to conclude, given that gap, that there had been no “abatement” [that is, a reduction] of a mild to moderate impairment from his first accident by the time he had his second accident. He gives the analogy of seeing someone in a wheelchair after a second car accident. If you had seen the same person shortly after he had injured his leg in an earlier car accident, but not in the intervening period, you could assume he had not recovered from the original injury. But if in fact in the intervening time between the two accidents, he had fully recovered but you did not know about his gradual recovery after the first accident, your assumption that his original leg injury had not “healed”, would be wrong.

- (31) The worker says that in 1982, just 13 months after his first accident, he was still recovering, when Dr. Bornstein last assessed him. In the time between his first and second accident, he says he got much better and points to the activities he was able to carry out, both at work and in his social and recreational life.
- (32) The worker says that since Dr. Snyder interviewed him and assessed him in person and since he specializes in head injuries, more weight should be put on his opinion (70% impairment) than on that of the medical consultant who did not examine him in person and who does not specialize in head injuries.
- (33) The worker says that the medical consultant should not have referred to the percentages from the second edition of the AMA Guides but should only have used the latest (4th) edition.
- (34) The worker says that the medical consultant should have examined him in person. He refers to the AMA Guides (4th edition), Chapter 14 at 14.7 which state that “medically determinable impairments in thinking, affect, intelligence, perception, judgment, and behaviour are assessed by direct observation, formal mental status examination, and neuropsychological testing.” [His emphasis.] He says without “direct observation”, the medical consultant had less information on which to base his evaluation of impairment than did the neuropsychologist.
- (35) The worker refers to the same Chapter at 14.2 which states that “the individual’s own description of his or her functioning and limitations is an important source of information. The presence of a mental disorder does not automatically rule out the individual as a reliable source of information. Information from non-medical sources such as family members and others who have knowledge of the patient, may be useful in indicating the level of functioning and the severity of the impairment. . . [and] may be used to obtain detailed descriptions of the individual’s activities of daily living, social functioning, concentration, pace, and persistence and ability to tolerate increased mental demands (stress).”
- (36) The worker provided evidence of his current social functioning. He says he doesn’t like being around people. One person is fine but if another person comes up to him when he is talking to someone one-on-one, he leaves because it is too much for him.

He says he had a partner before his 1992 accident (and he was engaged to her) but after the accident, he was so changed that the relationship dissolved. He says having a partner now would be too much for him. He says he has a history of altercations with people and has been in a number of small claims court cases because people take advantage of him now. He says he fears strangers. He says he avoids interpersonal relationships because they are so stressful to him. He lives alone out of town and has no social or recreational activities.

- (37) With respect to the activities of daily living, the worker says he doesn't eat very well and takes sleeping pills every night. He says he often becomes frustrated because he routinely misplaces things: he has to have 5 hammers because he keeps forgetting where they are-- he puts one down, forgets, and then finds it later in the most inappropriate place. He says that he has difficulties managing his finances. He says that he lost a large sum of money by buying investments that then declined in value. He says he should have paid down his debt instead. He says he has organized his life to reduce stress – this includes living by himself, but also scheduling any appointments for the morning because by 11 or 12 o'clock, he is “stressed out”. He says on bad days, his ability to cope can sometimes fail even before 11 a.m.
- (38) With respect to how he functions in work settings, the worker says that when he went back to work after his 1992 accident, he was in a modified position. He says he was basically the “weigh scale person” – he weighed trucks. He says he tried to remember how to lay out a curb, work that he had done before, but it took a lot of time and stressed him out. In addition, he says that since the 1992 injury, he avoids peer interactions that come with a work environment because they are so stressful to him.
- (39) With respect to concentration, persistence and pace, see the remarks about stress after the morning in paragraph 37. The worker also says that he is unable to read – an activity that gave him a great deal of pleasure before the 1992 accident. He says his memory problems make it impossible to hold the necessary details in mind to make sense of a story. He says he cannot listen to the radio most of the time either, something he used to enjoy. He says he cannot listen and do something else like drive.

The Issue

What is the “percentage of the worker’s permanent impairment” for the purposes of calculating the compensation he is entitled to under section 20 of the *Act*?

Analysis

According to section 90.(1) (b) of the *Act*, the worker's entitlement to compensation must be determined by *Worker's Compensation Act*, R.S.Y. 1986 as amended up to September, 1992 when the disability arose. Section 14 (2) states:

Where a permanent disability results from an accident, the evaluation of the worker's disability shall be made on behalf of the board by one medical and one non-medical person selected by the board.

We note that the undefined term "medical person" is used and not "medical practitioner" which is defined in the *Act* as a person who is authorized by law to practice medicine. We emphasize that the *Act* calls for the decision under section 14 (2) to be made by a medical and a non-medical person – we interpret the non-medical person to be a reference to an adjudicator (or others in an adjudicative role on an appeal, such as the hearing officer and the appeal committee.) In other words, the medical person's opinion is only part of the evaluation process for permanent impairments.

As well, the *Act* says in section 1 that a permanent total disability includes [but is not limited to] "(f) any injury to the skull resulting in an incurable incapacitating mental disorder." We find that the worker's condition as a result of the 1992 compensable injury comes within the definition.

In addition, section 42 of the *Act* provides:

- (1) Where a worker is entitled to compensation because of an accident occurring after 1982 that causes permanent disability he shall be paid, on account of the disability but not on account of any impairment of his earning capacity, a lump sum award in an amount calculated in accordance with subsection (2).
- (2) The board shall by order establish a rating schedule for application in calculating the amounts of awards made under subsection (1).

There is a board order dated 1987/03 which says "the physical impairment rating schedule to be used for the determination of the percentage of physical impairment shall be the American Medical Association Evaluation of Permanent Impairment Guide." There is also board Policy No. 24, "Permanent Physical Impairment." This policy, like the board order, says that the PPI award is to be based on the AMA Guide. It also says that the award is set by a claims officer and one medical person and is based on the schedule. It states that it is at the discretion of the medical consultant as to whether a worker requires examination at the board office or whether information provided by external medical examiners is sufficient. The policy does provide some guidance on conditions where there would be no need to personally examine the worker – (1) where the worker has returned to his pre-accident employment with no difficulties and (2) where there are no medical complications. (We note that at least the first and probably the

second of these conditions do not apply to this worker. In our view, he should have been personally examined by the medical consultant.)

Both the board order and Policy No. 24 refer to “physical” impairments rather than “mental or behavioural” impairments. However, we think that the physical trauma of the 1992 accident accounts for the worker’s impairment, which likely has an organic basis.

We have not addressed board Policy CL-46 because it was passed after the 1992 injury and was written according to changes in the law which became effective in 1993. However, we find nothing in that policy which would alter our decision.

In our view according to section 14 (2) of the *Act*, it is necessary for the adjudicator and hearing officer to play an active role in evaluating the level of impairment a worker. This active role includes both considering and questioning, if necessary, the validity of a medical opinion -- is it comprehensive? Does it accord with the other medical evidence on file such as assessments of neuropsychological functioning by a specialist neurologist? It is wrong to assume that an adjudicator or hearing officer must simply accept the “medical person’s” opinion, without any analysis of it. It is also wrong to conclude that the adjudicator or hearing officer can only question a medical opinion if there is a contradictory medical opinion from another doctor. In our view, if there is assessment information in the file from a specialist who is not a doctor and that assessment conflicts on a key point (such as the percentage of impairment) with the medical opinion (as is the case here), the adjudicator or hearing officer should consider why, rather than simply deferring to the medical consultant’s opinion.

In this case, the medical consultant encouraged the adjudicator (correctly in our view) to “interpret” the information he gave her, based on the AMA Guides. He also emphasized that classification of mental and behavioural impairments is an “extremely complex area”. Again, we note that the medical consultant uses conditional language – he says that the worker “may” be in the Class 3 level of impairment.

We find that the correct percentage of this worker’s impairment of the whole person due to his work-related head injury is 70%, not 40%. We rely on Dr. Snyder’s 1994 assessment in this regard: he stated that the worker’s “emotional disturbance under the present circumstances of mild-to-moderate stress is of severe degree and represents an estimated 70 percent impairment of the whole person.” It is true that he goes to predict that with appropriate treatment and normalization of stress this percentage could be reduced to a mild-to-moderate level but this would “depend” on some improvement in complex, integrated cerebral functions. We note that in his most recent 1999 assessment that Dr. Snyder finds that the results of testing showed minimal change in the level of neuropsychological functioning of any practical significance from 1994. Also, it is now almost eight years since the 1992 head injury. As the rehabilitation counselor pointed out (see paragraph 16), this is a significant period of time to go without effective treatment of

the worker's most debilitating problems (possibly a case of "too little, too late"). No one can accurately predict how effective treatment at this late stage might be; meanwhile, the worker has been attempting to cope for almost eight years with a significant impairment. In the circumstances, we find no reason to speculatively reduce the award from 70% based on possible improvement due to treatment not yet begun— at law, the award must reflect his current level of impairment which has apparently not diminished since the 1992 injury.

In coming to our determination of a 70% impairment, we also rely on the evidence provided by the worker at the hearing -- specifically, his testimony with regard to his current social functioning (see paragraph 36); his activities of daily living (see paragraph 37); his deterioration in work settings (see paragraph 38); and his diminished capacity to concentrate, pace and persist (see paragraph 39). We had the added advantage of observing the worker throughout the hearing, particularly with respect to his ability to concentrate over three and a half hours. We think that this evidence as well as that of Dr. Snyder is consistent with a Class 4 impairment under the AMA Guides – a condition where useful functioning is severely impeded. We find that Dr. Snyder's assessment of a 70% impairment should be given greater weight than the more qualified opinion of the medical consultant who did not examine the worker, did not specifically address the area of ability to pace, concentrate and persist, and who did not refer to Dr. Snyder's 70% impairment figure yet relied on and quoted from Dr. Snyder's assessments.

Finally, we also find that there should be no deduction from the award for a pre-existing condition. We find that there is insufficient evidence for such a deduction: there is no assessment of the worker's functioning for over a decade from 1982 to 1994, two years after his 1992 injury. With respect to whether or not the worker's psychological condition had "abated", there is no assessment closer than 1982 to the 1992 injury. It is well established that head injuries can take a long period of time to heal. An assessment only 14 months after a serious head injury (that is, the 1980 injury) would necessarily miss any continuing recovery and improvement in function throughout the 1980's and early 1990's. We further find that the worker has provided ample evidence in his testimony with respect to his work and social and personal activities just prior to the 1992 accident which indicates high functioning and excellent recovery in terms of his mental and behavioural condition from the 1980 accident. He was a successful competitive athlete in a team sport; he taught high school students this sport for four years with a curriculum he had designed; he was working in a supervisory position; and he had an active and full social and recreational life.

Conclusion

The appeal is allowed. The worker's impairment of the whole person due to his work-related 1992 head injury is 70%, not 40%. Therefore, the decision of the hearing officer is varied or changed and the worker's permanent partial impairment award must be adjusted to reflect the new percentage.

Dated this 27th day of July, 2000 in the City of Whitehorse, in the Yukon Territory.

Jan Stick, Member

Heather MacFadgen, Presiding Officer

Joseph P. Radwanski, Member