

Workers' Compensation Appeal Tribunal

Decision # 4

Claim No.: 97-1400

Date of Hearing: August 28, 2000

Date of Decision: October 20, 2000

Appeal Committee Members

Presiding Officer:	Heather MacFadgen
Member representative of employers:	Jan Stick
Member representative of workers:	Karen Waroway

In attendance: The Worker
The Worker's representative – Michael Travill
Witness via telephone connection – Dr. Skinner
Observer from the Workers' Advocate's office – Julie Docherty
Reporter/Recorder – Doug Ayers

Location: Boardroom 1B Main, 419 Range Road
Whitehorse, Yukon Territory

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Introduction

The worker appeals the decision of the Workers' Compensation Health and Safety Board ("board") Internal Review Committee ("IRC") dated November 3, 1999.

In its decision, the IRC upheld the April 12, 1999 and June 21, 1999 decisions of a board adjudicator. The adjudicator's decision of April 12, 1999 advised the worker that his benefits would change from temporary total disability benefits to re-employment assistance benefits with entitlement for three months if the worker looked for employment. The letter states that "it appears that chronic pain . . . is [the worker's] only remaining disability" and also states that the board "does not recognize chronic pain as a disability for entitlement purposes." [See Policy CS-01.] The adjudicator's decision of June 21, 1999 decides that the worker does not have any remaining measurable permanent clinical impairment; therefore, the board will not accept any further responsibility for medical treatment, prescription costs or wage loss benefits.

The worker argues that he is still disabled as a result of the October 2, 1997 accident and is entitled to compensation benefits including temporary disability and/or wage loss, reimbursement for medical expenses and rehabilitation services. Further, the worker and his representative disagree with the IRC's interpretation of board Policy CS-01 and its application to the worker. The worker requests that the appeal committee find that board Policy CS-01 must be interpreted in a manner which complies with the *Workers' Compensation Act* ("Act") and does not deny the worker compensation otherwise payable under the *Act* for a work-related disability.

On April 1, 2000, the Workers' Compensation appeal tribunal came into existence under amendments to the *Act* known as Bill 83. On May 16, 2000 the worker appealed the IRC decision to the new tribunal and 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.

This hearing was originally set down for hearing on July 26, 2000. The workers' advocate requested a postponement of the hearing date on July 25, 2000. The hearing was rescheduled and heard on August 28, 2000 in Boardroom 1B Main, 419 Range Road, Whitehorse, Yukon.

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 attended the hearing and gave evidence by affirmation. The worker was represented by Worker's Advocate, Mike Travill. No one appeared on behalf of the employer. The proceedings were recorded by court reporter Doug Ayers.

The appeal committee considered all of the worker's record as provided by the board as well as board policies CS-01, "Treatment," and BD-04 , "Development and Application

of Board Policy,” also provided by the board as relevant to the matter under appeal according to section 18.3 (4) of the *Act*.

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

Exhibit 1: Page 401 – 403 – Yukon Work Futures – A Guide to Work Opportunities

Exhibit 2: Page 58 - 60 - Worker’s Compensation in Canada, 2nd Edition, by Terence G. Ison

Exhibit 3: Addendum Report by Dr. W. G. Keenan, dated June 26, 2000 with handwritten notes by Dr. Skinner dated August 28, 2000.

Exhibit 4: Pages 36 – 38 - Worker’s Compensation in Canada, 2nd Edition, by Terence G. Ison

Exhibit 5: Page 962 – Black’s Law Dictionary, Abridged Sixth Edition

Exhibit 6: X-ray reports dated June 26, 2000 of
- Pelvis, bilateral hips and sacroiliac joints
- Sacroiliac joints lumbosacral spine by Dr. R. Sherlock

Exhibit 7: Page 21 - Worker’s Compensation in Canada, 2nd Edition, by Terence G. Ison

Exhibit 8: Page 27 - Worker’s Compensation in Canada, 2nd Edition, by Terence G. Ison

Lastly, prior to the hearing the Workers’ Advocate was given a File Summary and tabbed Documents relating to the appeal prepared by tribunal staff for easy reference to documents from the worker’s record during the hearing.

At the outset of the hearing, the Chair stated that new evidence submitted at the hearing would be provided to the board, unless the worker or his representative raised an objection to doing so. Neither objected.

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 parties' privacy, in any quote or reference to the worker or employer by name, we have substituted the word "worker," or "he," or "employer," etc. We have also used initials rather than the full name of doctors, and other professionals, except for Dr. Skinner, who testified.

NOTE: Many of the doctor's medical reports are handwritten with numerous medical abbreviations. For the convenience of the reader, for the excerpts from medical reports included in this file summary, such abbreviations are spelled out. If any words or abbreviations are uncertain (due to unclear handwriting), they are followed by a question mark in square brackets [?]. Gaps due to unreadable words are indicated by [. . . ?].

- (1) The Internal Review Committee ("IRC") concluded that the worker was injured on October 2, 1997 when he fell to the ground because he missed the last step on a ladder while dismounting from his front-end loader.

The IRC concludes that Dr. Skinner's opinion – "that there is some unidentified abnormality in the nervous system which has occurred because of damage to other tissues. . . is based on theories regarding neuropathic pain . . . which is a very complex area." The IRC agrees that the worker is in persistent pain which has impacted on his life and concludes that "the only factor keeping the worker from returning to employment is his persistent pain." The IRC acknowledges that the pain "could be . . . work related" although there are pre-accident factors that might be involved such as diabetes. Finally, the IRC states Board Policy CS-01 "does not consider the origin of chronic pain or a chronic pain disorder" and only allows treatment of these conditions for a period of up to six weeks if the pain is hindering a return to work. It then states that no benefits are payable due to chronic pain after this six weeks of treatment. Therefore, the IRC confirms the adjudicator's April 12 and June 21, 1999 decisions.

- (2) The Worker's Report of Injury/Illness, dated October 27, 1997 states that the worker was stepping out of a loader and missed the last step, causing him to fall and injure his lower back and tailbone.

The report also states the worker earned \$21.37 per hour for a 40-hour work week as a seasonal/casual worker with estimated total earnings of \$52,000 for the past 12 months.

- (3) The Employer's Report of Injury/Illness dated October 3, 1997 and signed by the Acting Foreman states that the worker was stepping out of a loader and missed the last step.

The report states the worker began working for the company on May 1, 1989 and that he was paid \$21.27 per hour for a 40-hour work week as a seasonal/casual employee with gross earnings for the past 12 months of \$52,000.

- (4) The Doctor's First Report dated October 3, 1997 states the worker was examined at Whitehorse General Hospital by RZ or RN [?]. The report lists Dr. B. as the family physician. The diagnosis is a bruised coccyx [tailbone]. On examination, the doctor reports tenderness over the coccyx and reflexes are 2+ bilaterally. X-rays are ordered with a treatment plan that states no sitting for a week and follow-up with Dr. F. in 5 – 7 days. The treating physician under "Any Factors that Might Complicate Recovery?" states, "Could take a time to heal ? dislocated coccyx."
- (5) The X-ray report dated October 10, 1997 by I. Oates, M.B. states, "The coccyx is slightly displaced posteriorly with respect to the sacrum. This slight dislocation could be traumatic or congenital in nature."
- (6) Dr. F.'s report dated October 10, 1997 diagnoses the worker with a coccygeal contusion. Dr. F. finds, "pain in tailbone – no leg symptoms. Back range of motion is poor especially on flexion." A rectal examination is done. The doctor states, "extreme tenderness of coccyx and of sacrotuberous ligaments, greater on the right than on the left." The doctor recommends short walks and avoidance of prolonged sitting – less than 30 minutes. He also states, "cannot operate vehicles since this involves sitting." The estimated date of return to work is listed as October 31, 1997.
- (7) Dr. F.'s report dated October 28, 1997 reports, "continuing pain in coccyx – most comfortable standing; anal and bladder sphincters – poor control because of pain. The worker reports occasional incontinence of both the bladder and bowels. On examination, the doctor notes "poor range of motion in the back; rectal-sphincter tone fair with still extreme tenderness of the coccyx and S/T ligaments." The worker is referred to the POWER program with a return to work date "unknown – likely prolonged convalescence."
- (8) In the POWER Program Initial Assessment Findings dated November 10, 1997 the occupational therapist and physical therapist report under Special Considerations/Concerns: "This man has several pre-existing conditions, as well as obesity." There is "decreased range of motion in the lumbar spine and right hip . . . with marked spasm and pain in bilateral hip rotators, quadratus lumborum and gluteal muscles. . . coccyx situated in a flexed position of the distal tip to the left." Recommendations are six weeks at the POWER Program and "as this client is very

deconditioned, a general and specific activity program will also be incorporated into his programming.”

- (9) The worker attends the POWER Program but progresses very slowly. Reports from the POWER Program, dated November 25, December 9, December 10, and December 24, 1997 and January 8, 1998 indicate continuing pain in the right hip, right knee and coccyx. The return to work date keeps being extended. The worker is treated with coccygeal muscle release 2 to three times per week which seems to offer some relief.
- (10) A note to file by a board rehabilitation counsellor dated November 24, 1997 states, “the internal manipulation is done approximately two times per week with good response. Bowel and bladder function are back to normal. General conditioning exercises are being done with deep heat treatments to the coccyx area.”
- (11) A letter to Dr. D. B., Health Resource Centre, dated January 14, 1998, from the Rehabilitation counsellor refers the worker for assessment of his lower back/coccyx area. The rehabilitation counsellor asks, “Could the injury be more complex than this as [the worker’s] progress is very slow or are the factors of the slow progression attributed to the pre-existing conditions --diabetes or obesity?” Dr. D.B. did not do an assessment because the worker could not be accommodated for an MRI because of his size.
- (12) Dr. P.'s report dated January 5, 1998 states that “[the worker] is still having some right hip pain and having difficulty. He does not feel he would be able to sit in a loader for long periods of time at present.” The doctor changes the estimated return to work date to February 1, 1998.
- (13) A note to file by the rehabilitation counsellor dated January 22, 1998 notes that the worker cannot be accommodated for an MRI in Calgary because of his size (over 300 lbs.).
- (14) A letter from the rehabilitation counsellor to Dr. I.S., an orthopaedic surgeon in California, dated February 3, 1998 refers the worker for an MRI and orthopaedic consultation.

(15) Dr. P.'s report, dated January 30, 1998 states that the worker is still experiencing right leg pain and does not appear to be improving. The doctor questions whether there may be a possibility of "nerve impingement" and extends the return to work date from February 1, 1998 to March 1, 1998 adding, "but this is uncertain, as we are uncertain to the diagnosis right now." [as written]

(16) The orthopaedic consultation report dated February 17, 1998 done by Dr. I. S., an orthopaedic surgeon, reports:

Diagnostic Impression:

- 1) lumbar sprain/strain
- 2) lumbar facet syndrome (due to jamming force as he fell)
- 3) right trochanteric bursitis
- 4) fractured coccyx

The physical examination reveals palpable tenderness over the lumbosacral spinous processes from L4 to S1, posterior superior iliac spine, lumbar paravertebral musculature, sacroiliac joints and greater trochanter on the left side with crepitus and restricted range of motion of the lumbosacral spine.

There is no neurologic deficit.

This patient has no medical history of relevant injuries to his low back, hip and coccyx. From an orthopaedic standpoint, his findings are all compatible with the above-diagnostic impression. In my opinion, his current condition is entirely a result of the specific industrial injury on 10/03/97. [Emphasis added.]

[Dr. I. S. recommends] physical therapy for the hip with treatment modalities to include ultrasound, hot packs, transcutaneous electrical nerve stimulation (TENS), repeat steroids to the right trochanter and a rubber tire for the coccyx and analgesics [and prescribes] non-steroidal, anti-inflammatory medication.

(17) Dr. K. reports on an MRI of the lumbar spine, dated February 17, 1998 as follows:

MRI of the lumbar spine demonstrates normal lumbar spine curvature.

There is no bone marrow abnormality in the vertebral bodies. The visualized portion of the conus medullaris, cauda equina and filum terminale are normal." At L5-S1 "There is mild desiccation of the disk with a 3 mm bulge with annular tear. This has caused some pressure over the thecal sac. There are hypertrophic changes of the facet joints. There is mild to moderate spinal stenosis.

- (18) Dr. F.'s report dated March 5, 1998 states that the worker has increasingly poor control of his bowel and bladder functions with continuing pain in the lower back and right hip. Dr. F. states there is poor range of motion in the spine and the right trochanteric bursa is tender with a "palpable click". He questions whether there is a possible cauda equina syndrome and recommends a consultation with a neurosurgeon [?].
- (19) A memo to the board medical consultant from the rehabilitation counsellor dated March 6, 1998 asks him to review the assessment report. She says "it appears from the MRI report that the coccyx area was not imaged as requested."
- (20) The medical consultant in a report dated March 9, 1998 agrees with Dr. F. that the worker should be evaluated by a neurosurgeon or neurologist. The medical consultant states:
On the MRI there was a 3 mm bulge of the L5-S1 disc. There were hypertrophic changes of facet joints with mild to moderate spinal stenosis which would have predated the incident at work. At the L2-3 level there was a mild desiccation of the disc which . . . would likely have pre-existed the incident at work. However the small annual tear at the L5-S1 level may well have occurred from the fall. [Emphasis added.]
- The worker may have a small permanent impairment of function as a result of this injury but normally one would anticipate the ability to return to his normal employment. Treatment really consists of managing the pain while increasing the worker's activity level which might be best accomplished by a return to a suitable employment.
- (21) Dr. F.'s report, dated March 10, 1998 states, "no change since 5 Mar visit except for now daily urinary incontinence."
- (22) A letter, dated March 19, 1998, from the rehabilitation counsellor to Dr. S., a neurologist at the Health Resource Centre refers the worker for an assessment as follows: "What is the probable cause of the bladder/bowel symptoms?" and "Could the current bladder/bowel symptoms be related to the fall onto the coccyx?"
- (23) In his report dated April 2, 1998, Dr. S. states:
. . . has sustained a significant musculoskeletal injury with resultant myofascial pain syndrome. With respect to the bowel and bladder dysfunction, I cannot find any evidence of injury to the conus or cauda equina clinically. I feel that his symptoms of bladder and bowel urgency . . . are most likely nonspecific

effects of the injury and severe pain that he is experiencing.

. . . I agree that the severity of his pain syndrome is most likely related to his size, due to his obesity. **I do not feel that there is any evidence of a diabetic neuropathy which is contributing to his symptoms.** [Emphasis added]

- (24) Dr. M., an orthopedic surgeon in a report dated April 3, 1998 states, “. . . any attempt to rotate passively the hip or resisted external and internal rotation of the hip caused acute pain in the posterior buttock but even more acute into the posterior groin. . . . There is a possibility of a stress fracture or possible crack in the femur in the femoral neck region and/or over the sacrum and I feel that these are important to rule out . . .” Dr. M. recommends X-rays and a bone scan.
- (25) Dr. M.’s report of the x-rays and bone scan of the right hip, dated May 1, 1998 states: “. . . there is no sign of any stress fracture or other fracture or inflammatory lesion. I would suggest that his current problems are stemming more likely from contusional injury to the soft tissues of the hip . . . However, no surgical procedure is indicated.” [Note: this statement with respect to cause of problems is made six months after the date of the worker’s initial injury.]
- (26) Dr. F.’s report dated April 16, 1998 states that there has been “no change since exam 98 Mar 24” and that the worker is “totally unfit for any occupation.”
- (27) A note to file dated April 24, 1998, by the rehabilitation counsellor reports that in a discussion of the worker with Dr. F., the doctor reports that the worker will probably not be able to return to his previous job for at least another six months and “he realizes the difficulty in determining which factors are pre-existing and which are due to the injury.” The notes also indicate a phone call to the worker in which he informs the rehabilitation counsellor that he tries to walk daily and has been trying to do physio but “finds it difficult due to the pain.” The rehabilitation counsellor explains that one of the specialist’s reports suggested myofascial pain syndrome and the other “questioned the possibility of a crack at the head of the femur.” If the reports of the bone scan and X-rays return negative they will be “looking at myofascial pain syndrome for which [the board] provides treatment up to six weeks either at a chronic pain management agency or with Dr. Skinner.” The note states that the worker says “he had never had these type of problems before he fell.”

- (28) A letter dated May 4, 1998 to Dr. Skinner from the rehabilitation counsellor asks that he review the medical documentation prior to a possible assessment. She reports that Dr. F. agreed that “a form of pain management may be of benefit . . .”.
- (29) Dr. Skinner’s response dated May 19, 1998 states, “what I believe to be pertinent statements as well as omissions” in the reports sent to him for review. Dr. Skinner states:

Since no previous reports have apparently described the accident in detail, I will note them here. It was 2:00 PM on October 2, 1997 that while dismounting his grader in the usual fashion, that is, backwards, his foot missed a step and the 4 steps below it. He lost his handgrips and fell, he estimates, at least 6 feet landing on his right buttock with elbow flexed and arm well adducted to his torso. He stated that other workers saw that his “feet were off the ground” at the moment of impact and that he then rolled to land on his right upper arm and shoulder. He was very short of breath and unable to talk for some time after the impact. Two hours later there was much more pain in the hip and arm with marked decrease in range of movement.

. . . this man primarily suffers post-traumatic myofascial trigger point pain syndrome involving the soft tissues of the right buttock. More specifically, these are piriformis, the gluteal muscles and secondary reactors including iliopsoas and the paraspinal muscles. It also appears that he has developed an L5-S1 pseudosciatica secondary to muscle spasm in the buttock with an associated sensory loss. Consistent with heavy impact to the lumbosacroccygeal spine he has also developed sacral plexus dysfunction manifesting as bladder and bowel incontinence and impotence.

. . . I believe it important to emphasize that this man, overweight by 250 lbs., fell 6 feet, landing all of his weight on his right posterior pelvic area and then his right shoulder girdle. The force of the blow was also indicated by his loss of breath for some time after impact. He has suffered very significant deep soft tissue injury. With the mechanical forces involved, he has also suffered lower spinal impaction strain with resultant swelling and pressure on various nerve roots giving the sacral plexus dysfunction. These nerves, via the pudendal nerve, innervate the coccyx, as well as the bladder. Splanchnic nerves L1 and 2 also innervate the bladder via the sympathetic trunk. It is entirely appropriate that he has developed these organ dysfunctions with his injuries. However, I expect them to resolve completely unless disc collapse is present. [Emphasis added.]

- (30) Dr. Skinner suggests “deactivation of the trigger points by dry needling and/or dilute procaine injections 10 – 15 times over the next 4 to 8 weeks.” He suggests that the worker continue stretching and exercising at home and a referral to Riverfront Physiotherapy to “assist in assessment, mobilization, instruction on stretches and active exercise, as well as ongoing monitoring.”
- (31) In her Physical Therapy First Report dated May 22, 1998, the physiotherapist, A. McN. reports the right hip and lumbar spine have moderate restriction with multiple gluteal trigger points on palpation and hypertonus. For “Treatment and recommendations” she suggests manual therapy and exercise instruction three times a week for eight weeks. She reports that the injury is preventing the worker from returning to pre-accident work and that no “modified” or “alternate” worker can be performed.
- (32) Dr. Skinner’s report dated June 3, 1998 states that the worker “says the pain I get now is bearable” and admits to 20% overall improvement. “The worker has received eight dry needling treatments and three trigger point injections. He is still experiencing a click in the right hip area.” Dr. Skinner estimates that 10 to 15 more dry needling of trigger points will be required.
- (33) Dr. Skinner’s report dated June 29, 1998 states that the worker is walking for a mile with less hip pain but now his leg “goes numb”. There is persistent right hip pain, throbbing into the groin and postlateral hip. On examination, “still marked tenderness soft tissues buttock to groin, . . . marked by pain flex . . . relieved by traction.” Dr. Skinner will discuss with Dr. P. and Dr. D. to determine whether the worker needs an arthrogram. He states, “totally disabled [from performing] manual work.”
- (34) A letter from Dr. Skinner to Dr. D. dated June 30, 1998 requests that Dr. D. perform a diagnostic hip block on the worker. He states, “With the help of [the physiotherapist] . . . , we have succeeded in reducing his low back, buttock area and leg symptoms by about 75%. . . . His major new problem is persistent, severe pain on any mobilization of the right hip joint. . . . I believe a diagnostic block would tell us whether or not his symptoms are from intraarticular or extrarticular pathology.”
- (35) The bone scan of the thoracic and lumbar spine, pelvis and hips, completed on April 6, 1998 by Elliott Fong Wallace and Associates states, “The pelvis and right hip are normal. The lateral view shows the coccyx to be retroverted. There is, however, no evidence of a fracture either radiographically or on the bone scan of the same day.”

- (36) Dr. Skinner's report to Dr. P., dated July 10, 1998 states that the initial right hip block done by Dr. D. and Dr. S. had positive results with increased external and internal rotation before onset of pain.

Dr. Skinner also reports, "It was also noteworthy that [the worker] no longer had pain when lying on the right side bearing all of his weight on the right greater trochanter, something he had been unable to do since his injury. In summary, this hip block shows that he has significantly decreased pain on all articular tests. (Of course he still has extra articular neuropathic and myofascial pain.)" Dr. Skinner asks Dr. P. whether the worker should have another bone scan and/or arthroscopy.

- (37) The report by the physiotherapist, A. McN. dated July 13, 1998 states that the worker was assessed immediately following the right hip block. The worker presented with overall improvement although he "expressed excruciating pain in the groin and buttock within 8 hours following the injection." Her impression is "that there is intra-articular involvement as all articular signs improved immediately following the injection."
- (38) Dr. D.'s letter to Dr. Skinner dated July 13, 1998 suggests that to "rule out pain secondary to hip joint pathology a series of three blocks should be performed."
- (39) Dr. Skinner reports on July 22, 23 and 24, 1998. On July 22 the worker reports that after the first injection he "did a lot more walking on it than usual and thus experienced severe pain later and especially the next few days. . . . pain as bad as it ever was" The worker is scheduled for two more hip blocks on July 24 and August 7, "double-blinded, that is saline in one, xylocaine in other."
- (40) The worker visits the physiotherapist immediately following the third hip block. Her report, dated August 7, 1998, states,

Unfortunately, following the injection on August 7, 1998 the findings only changed minimally. . . . Symptomatically, the worker did report less . . . pain overall.

My impression is that the injection on this occasion was not as successful in the reduction of his symptoms and improvement of objective findings. While some improvement in groin pain was noted the selective tissue testing was relatively inconclusive in differentiating between intra-articular and extra articular symptoms.

- (41) Dr. P.'s report states, "In the absence of abnormality on plain radiographs and bone scan, it would appear there is no bony problem to account for his symptoms. One wonders, on the basis of his block, if he has a soft tissue problem related to the hip joint specifically. I would recommend that the patient have an MRI scan from above the hip joint to look for correctable lesions."
- (42) Dr. Skinner's report dated August 12, 1998 states that the worker, "does, indeed, have hip joint pathology which is a major contributor to his pain complex subsequent to his injury of October 7, 1997." Dr. Skinner requests an MRI and if indicated, an arthroscopy. He also reports "mild pain relief" for about an hour after the third hip block.
- (43) The Physical Therapy Progress report dated August 14, 1998 by the physiotherapist finds that the worker is still experiencing lumbosacral and groin pain and recommends the worker use a TENS machine at home with follow-up in two weeks.
- (44) An MRI report dated September 8, 1998 by Dr. Do. reports that the "right hip is within normal limits . . . Increased T2 signal is seen in the left lateral aspect of the body of S1 . . . This area is only partially imaged on a coronal T1 weighted sequence which shows normal appearing intensity. While this finding most likely represents MR artifact, bone pathology cannot definitely be excluded."
- (45) The rehabilitation counsellor's note to file dated September 18, 1998 notes that she has spoken with Dr. Skinner. Dr. Skinner states that Dr. P. noticed some abnormality in the right hip. Dr. Skinner requests a second opinion of the MRI and asks Dr. P. for names of MRI experts.
- (46) A progress report by M. McC., physiotherapist, dated September 18, 1998 states "There has not been any significant change in objective findings since August 14, 1998." She suggests a "more aggressive exercise program in an attempt to improve his functional levels."
- (47) Dr. Skinner's report dated October 8, 1998 reports on a group meeting with the worker, the worker's wife, physiotherapist, and doctor to assess the worker's current status and develop a program for therapeutic management. Dr. Skinner says he will discuss a "return to some sort of fairly sedentary light duty position at his employment place which allows the worker to move up and down from various positions."

- (48) A letter from Dr. Skinner to Dr. H. dated September 21, 1998 requests his second opinion of the previous MRI.
- (49) Dr. H.'s report, dated October 27, 1998 states his interpretation of the MRI. He finds "a small joint effusion . . . on the right hip. However, no marrow signal abnormality . . . the acetabular labrum is faintly visualized and there is no gross abnormality but an MR arthrogram would be necessary to evaluate this structure in any detail. . . . A small right hip joint effusion is present but no other joint abnormality is seen. There is mild disuse muscular atrophy and coincidental degenerative changes in the pubic symphysis." [Emphasis added.]
- (50) A Functional Capacity Evaluation (FCE) is done October 27 and 28, 1998 by W.S., occupational therapist and S.R., physical therapist. The report shows the worker is capable of doing light work but he would not be able to safely perform work duties as a heavy equipment operator.
- (51) A memo dated December 14, 1998 from the rehabilitation counsellor to the board medical consultant asks if the worker has chronic pain/chronic pain syndrome and whether or not he has impairment of function due to the October 1997 injury.
- (52) The medical consultant examines the worker and reports on December 22, 1998, "I can find no objective evidence of neurologic or orthopedic disorder. I therefore believe that the most significant problem is chronic pain/chronic pain syndrome. At this point I can find no objective evidence of a permanent impairment of function as the result of the injury sustained in October of 1997. At present the primary limiting factor is pain."
- (53) The report from Voc-Aid Disability Management Services, dated December 21, 1998 suggests that the worker is capable of working in a number of lighter occupations such as video store clerk, service station or laundromat attendant. It sets out functional restrictions with respect to the lifting, carrying, standing and walking activities, as well as limitations in postural abilities such as climbing, balancing, stooping, kneeling, and crouching due to back pain. [This report also states the worker's "compensable disability" is "coccygeal contusion" and makes recommendations with respect to "deeming". Emphasis added.]
- (54) A Vocational Rehabilitation Report dated January 15, 1999 by the rehabilitation counsellor states, "[The worker] is attending a six-week pain management program from February 8 to March 19, 1999." Under Cost Analysis of Options, "The file shows that the only significant residual pain [the worker] is experiencing are that of

chronic pain/chronic pain syndrome. Policy CS-01. . . does not allow for compensation of this condition. . . . No wage loss is anticipated – the residual symptom of his injury is that of chronic pain/chronic pain syndrome – there are no objective findings on any investigative studies that can relate his ongoing pain to his work related injury.”

- (55) In a Doctor’s Report, dated January 15, 1999, Dr. Skinner states, “very sore, worse – codeine constipation and fear of becoming addictive; painful click (audible and palpable) especially after prolonged sitting.” The report states after the question, “Any change in diagnosis” (which is circled), “persistent post-traumatic work-related hip pain syndrome (neuropathic pain disorder)”.
- (56) Dr. Skinner’s letter to the medical consultant dated February 1, 1999 takes “very strong issue with your diagnosis” and states his concerns and objections to the medical consultant’s December 22, 1998 report, including the fact that the medical consultant arrived at a chronic pain/chronic pain syndrome diagnosis without discussing this with Dr. Skinner, the worker’s attending physician dealing with his pain symptoms. In part, his objections are that the medical consultant reported no objective evidence of neurologic or orthopedic disorder.

In this regard Dr. Skinner also states, “there are very few objective tests of neurologic disorder when it comes to pain. This would require high technology not available locally. He states the worker may have gone on to develop central (spinal cord) sensitization. He states, “I strongly disagree with you that he suffers from ‘chronic pain syndrome’. His persistent pain is neuropathic in origin.” He says the worker’s “clinical state does not fit the criteria for chronic pain syndrome in any way” and refers to Chapter 15 of the AMA Guides in this regard. Dr. Skinner suggests that the worker be assessed by a competent psychiatrist [Dr. Alex McKee at Viewpoint in Calgary] to obtain “advice on further diagnostic imaging such as an MR arthrogram.”

Another concern of Dr. Skinner’s is the medical consultant’s statements with respect to the worker’s pain behaviours. In this regard, Dr. Skinner states:

For diagnostic impression you [i.e. the medical consultant] note that ‘the most striking features of the examination are [the worker’s] pain behaviours.’ Again, I differ in that I did not find his behaviours inappropriate. You go on to say that you ‘can find no objective evidence of neurologic nor orthopedic disorder.’ I hope that you are not implying that he does not have a neurologic or orthopedic disorder but rather that you simply cannot find any . . .

Your physical examination does not include any comment on his complaint of a very severe, sharp painful click in the right hip joint area on weight bearing in gait. Neither do you mention that this is not only audible at times but palpable as this worker has stated that you noted during your examination of him. I believe this to be a very serious omission in your report. Would not your palpation on this click which the worker describes as his most severe pain be an objective finding on your part?

Although you can find ‘no objective evidence of a permanent impairment of function as a result of the injury’ I remind you to observe the man’s gait, his pain behaviour while sitting and standing, his reported increase of pain while weight bearing in association with a sharp, painful click, the relief of such pain with traction on the leg and the lack of an MR arthrogram clearly delineating whether or not there was traumatic pathology of the lip of the acetabulum.

- (57) Dr. Skinner’s letter to E.P., Columbia Rehabilitation Centre, dated February 1, 1999 addresses several concerns he has regarding the worker’s condition. He says the worker “has persistent pain because of undiagnosed and untreated tissue damage which includes the nerves per se” and pain “indicative of pathology of the hip joint and capsule per se. . . . The fact that we have not in Whitehorse been able to investigate his ongoing pain in order to come up with an objective finding does not mean that he does not have nerve injury. It is totally unacceptable to assume that because it isn’t found it does not therefore exist.” [Emphasis added]
- (58) A letter from the workers’ advocate to the rehabilitation counsellor dated February 2, 1999, asks several questions. The rehabilitation counsellor refers the letter to the board medical consultant. Following are the questions:
1. As the medical consultant diagnosed Chronic Pain (Syndrome) could you please elaborate for me what was the cause of the Chronic Pain (Syndrome)?
 2. Does that not therefore demonstrate arising out of and in the course of employment?
 3. If the condition did not arise out of or in the course of employment then does not CL-47 apply? If not, why not?
 4. What part of CS-01 lays out that entitlement is limited for disabilities arising out of or in the course of employment? Clearly, in the general information it is laid out that his policy covers conditions that are not disabilities arising out of or in the course of employment?
 5. Please ask the Medical Advisor why the worker does not qualify for a PPI under chapter 15 or page 113 (ii)(B).

- (59) The rehabilitation counsellor's response dated February 10, 1999 and the medical consultant's response dated February 9, 1999 indicate that it is premature to answer some of the questions that the Workers' Advocate has posed. In addition, the rehabilitation counsellor reports that the medical consultant has listed as contributing factors for chronic pain "childhood sexual abuse, personality disorders, compensation neurosis, inappropriate treatment, inappropriate prescribing of medications as well as multiple medical factors." [Note: This response does not answer the question of what caused this worker's chronic pain syndrome. It is a general statement concerning causes of chronic pain syndrome.]
- (60) The worker is sent to the Columbia Rehabilitation Centre on February 8, 1999 for assessment. The report by E.W., rehabilitation services coordinator, lists the admitting diagnosis as "right trochanteric bursitis and L5-S1 dessication of disc with annular tear."
- (61) The Columbia Rehabilitation Centre report by Dr. M. dated March 1, 1999 states, "[The worker] has evidence of underlying spinal degeneration on his MRI scan, however, there is no evidence of any neurologic impairment currently. He has multiple areas of tenderness consistent with myofascial pain. He has signs and symptoms suggestive of right hip pathology but in the context of exaggerated pain behaviour observed today, it is difficult to be certain whether this represent significant underlying right hip abnormalities. . . . I feel this man needs a right hip MR arthrogram. This is a more sensitive study for evaluating the integrity of the acetabular labrum as well as the cartilaginous components of his right hip joint." [Emphasis added.]
- (62) The March 8 and March 10, 1999 reports by Dr. H., also of the Columbia Rehabilitation Centre reports that the worker was referred for an MR arthrogram with respect to the right hip. She also reports that as a result of one month in the pain rehabilitation program the worker has discontinued all use of pain medication and improved his level of functioning, managing to walk one mile in 40 minutes, daily.
- (63) The Columbia Rehabilitation Centre Discharge Report dated March 19, 1999 under "Conclusions" states, "[The worker] has myofascial pain with increasing physical demands and is medically advised to avoid work of a physically heavy demanding nature and to avoid work requiring ladder climbing, frequent bending and awkward positions. He is also advised to avoid prolonged sustained sitting, standing or walking over irregular surfaces for prolonged periods. . . . Upon discharge, he was considered to be functioning at a sedentary level . . ." [Emphasis added.]

- (64) Dr. M.'s report on the results of the arthrogram, dated March 30, 1999 states:
- . . . [the worker] has had an MRI arthrogram of his right hip to evaluate the integrity of the right hip joint specifically. . . . The findings indicate no abnormalities within the right hip joint. The articular surface and labrum are normal. No evidence of significant degenerative changes. . . . With the evidence to date there is no indication that the right hip is the source of his pain. Rather the picture appears to be related to spinal degenerative changes in the lumbosacral region.
- (65) The worker visits Dr. Skinner for counselling for management of constant back and hip pain. In a letter to the adjudicator dated March 30, 1999, Dr. Skinner sets out the worker's daily program of stretching exercises as well as walking exercise. In addition he described the worker's frequent shifting of position for standing, sitting, lying down, to diminish pain which escalates without frequent movement.
- (66) The adjudicator's letter to the worker dated April 12, 1999 is a "follow-up to our many conversations and meetings." She reports, "[The board medical consultant] could find no objective signs to indicate a neurologic or orthopaedic disorder. His diagnosis is chronic pain/chronic pain syndrome. . . .the board does not recognize chronic pain as a disability for entitlement purposes. . . . When we last met I explained your benefits would change from disability to re-employment assistance benefits. . . . These benefits will be extended for the months April, May and June. . . . This claim will be reviewed for activity in June."
- (67) The worker visits Dr. Skinner on April 15, April 29, and May 13, 1999 with complaints of persistent pain. The report on March 15 states that the Columbia Pain Centre report erred when it stated the worker was no longer on pain medication. He had stopped taking codeine for pain at the time Dr. M. reported "exaggerated pain behaviour". He was, however, still on Gabapentin (analgesic). On May 15 the doctor's report states the worker had severe anterior hip pain for three days after chain sawing trees – "worst pain since injury."
- (68) The medical consultant's review of the Columbia Rehabilitation Centre's report is dated April 22, 1999. He notes that Dr. M. concludes as a result of the arthrogram findings that there is no indication that the right hip is the source of the worker's pain. He also notes the worker's fear of becoming addicted to analgesics is "quite real as it appears that the worker will have ongoing chronic pain."
- (69) The worker visits Dr. Skinner on June 3, 1999. Dr. Skinner reports, "[the worker] fell on May 25, severe exacerbation pain: sudden loss of power to leg, knee buckled

and landed full weight on right flexed knee on floor giving severe pain up leg, then hip girdle up spine to base of skull producing severe headache. . . recurrent urinary incontinence with movement.”

- (70) A letter to the worker from the adjudicator dated June 21, 1999 states, “Please be advised that it is my decision, based on the medical documentation on file that you do not have any remaining measurable permanent clinical impairment as a result of your October 2, 1997 injury.” The adjudicator confirms termination of the worker’s benefits effective June 30, 1999.
- (71) Dr. Skinner’s report dated June 25, 1999 states, “any lifting/carrying exacerbates pain. . . persistent (6 mo.) urinary incontinence.” He diagnoses “recurrent post-traumatic urinary continence. . . this man has developed neurogenic bladder again as a result of post-traumatic neuropathy sacral plexus (as he had for the first months of his injury.)”
- (72) On June 28, 1999 the worker appeals the adjudicator’s April 12 and June 21, 1999 decisions to the Internal Review Committee listing “ongoing responsibility and PPI [permanent partial impairment]” as the issue of appeal.
- (73) A memorandum to the board medical consultant from the rehabilitation counsellor dated July 20, 1999 requests that he review Dr. Skinner’s diagnosis of June 25, 1999 of “neurogenic bladder” with “persistent urinary incontinence over the past six months.”
- (74) The medical consultant’s report dated July 22, 1999 regarding Dr. Skinner’s June 25, 1999 diagnosis states, “I must admit I am rather confused with this diagnosis” because “neurogenic bladder” refers to retention of urine in the bladder rather than incontinence which is the worker’s reported symptom.” He concurs with Dr. Skinner’s recommendation of a urinary tract evaluation. However, the medical consultant notes the extensive evaluations that have been obtained by the Board to date have not demonstrated that the urinary problems are related to his injury.
- (75) Dr. Skinner’s letter to the medical consultant dated August 13, 1999 agrees that he misused the term “neurogenic bladder”: he says the correct term for the worker’s incontinence is “neuropathic urinary incontinence” caused by the workplace injury. Dr. Skinner quotes the worker - - “I wasn’t pissing my pants all the time before this injury” and reports. . . “pudendal nerve is giving him external sphincter problems. . . caused by the injury with its current complex pain disorder and not for reasons unrelated to injury. ”

- (76) The medical consultant's response dated September 2, 1999 accompanied by Board Policy GC -07, Role of the Medical Consultant states that he has "no authority to overturn or disregard a Board Policy."
- (77) On September 24, 1999, Sheri Hogeboom, Office of the Workers' Advocate, writes a letter to Dr. Skinner, posing five questions. He answers by letter dated September 24, 1999.

The questions with answers are as follows:

1. On your progress report of January 15, 1999 with respect to the worker, you made a diagnosis of "persistent post-traumatic work-related hip pain syndrome (neuropathic pain disorder)". In other letters (such as your letter to [the medical consultant] dated February 1, 1999) you use also the term "neuropathic pain" in relation to [the worker]. Could you please explain for the Internal Review Committee what this diagnosis means i.e., what is "neuropathic pain"?

Dr. Skinner:

Neuropathic pain is defined by the International Association for the Study of Pain as, "pain initiated or caused by a primary lesion or dysfunction in the nervous system." It is important to note by this definition that the pathology is not necessarily an actual lesion (physical damage) but can be pathology of function (neurochemical abnormality). This dysfunction or lesion may be in the peripheral nerves (e.g., to the hip) or in the central nervous system (spinal cord and brain) or both at once.

2. In your letter of August 13, 1999 to [the medical consultant], you state, "I have no doubt that he [i.e. the worker] has central sensitization (cellular neurologic change in the dorsal horn and other areas of the spinal cord) which leads to his persistent pain." Could you please explain in non-medical terms what you mean by that. What is the relationship between the "central sensitization" and the pain [the worker] is experiencing i.e. why or how does this cause pain?

Dr. Skinner:

The term "central sensitization" refers to the central nervous system (brain or spinal cord) becoming sensitized to pain stimulus such that it undergoes cellular and neurotransmitter (neurochemicals that transmit pain info) changes which, in turn, cause pain. This then is "central pain" and can be a consequence of persistent peripheral pain. In [the worker's] case I believe that his prolonged peripheral pain (buttock and hip pain persisting for many months after the injury) has, in turn, sensitized the spinal cord which continues to cause pain no matter what is done to the peripheral nerve sensors.

3. Thus, in your opinion, is there a medical reason for the pain that [the worker] is suffering?

Dr. Skinner:

In my opinion, the medical reason for [the worker's] pain is simply nerve damage, both peripheral and likely central, and that this damage is at least in neurotransmitter function and also likely in nerve cell changes in the spinal chord.

4. In your letter to [the medical consultant], dated August 13, 1999, you state that the worker's urinary incontinence is caused by the "neuropathic pain." Specifically, you state that the "pudendal nerve is giving him external sphincter problems." Can you explain what you mean by that, i.e. how or why is the incontinence caused by the nerve?

Dr. Skinner:

[The worker's] urinary incontinence, occurring when his pain is most severe, is also a result of bladder muscle and bladder outlet sphincter muscle dysfunction. Just as a low back strain can disturb bowel function or persistent low back pain can cause sexual dysfunction, so too have [the worker's] injuries to the buttock, hip girdle and lumbosacral spine area caused dysfunction of the sacral nerves supplying the pelvic floor (pudendal nerve) and bladder (vesical plexus). I have ruled out other causes of this urinary incontinence, something he did not suffer prior to his injury. Urodynamic studies by an urologist could verify this pathophysiology and assist in management.

5. In your opinion, was the damage to [the worker's] nervous system caused by the workplace injury which occurred on October 2, 1997, specifically a fall of approx. 6 feet onto [the worker's] back and tailbone area?

Dr. Skinner:

On October 2, 1997 [the worker] was climbing down the ladder from his loader when he missed the top step, falling the remaining 7 feet on to the hard ground. The first part of his body to hit the ground was the right hip and tailbone area which suffered widespread soft tissue (skin, muscle, ligaments, blood vessels and nerves) injury. Although most soft tissues have healed, the nerves supplying those tissues persist in signaling pain. They underwent changes in function resulting in persistent pain to light touch and pressure in the area, such as by lying on it or walking. This persistent peripheral nerve system dysfunction has, in my opinion, also resulted in central (spinal cord) sensitization causing persistent pain and pelvic organ dysfunction.

- (78) The medical consultant writes a letter to the IRC Chair, dated September 30, 1999 who requested information regarding neuropathic pain. He provides the same

definition as Dr. Skinner does and provides a number of possible causes for it including diabetes. He states:

Neuropathic pain is certainly a complex area. Evaluation must be thorough, as there are many potentially serious causes. This generally is beyond the scope of the Workers' Compensation system as the vast majority of the conditions are not work-related. A full evaluation often requires multiple investigations, often by several types of specialists in order to try to determine the underlying cause. Occasionally, no physical cause can be found.

Evidence and Argument from the Hearing

New Medical Reports

(79) The following new and additional reports were filed during the course of the hearing (by fax from Dr. Skinner's office) and entered as Exhibit 6:

- (a) An x-ray report dated July 19, 2000 by Dr. Sherlock numbered 2606-0018,0019 entitled "Sacroiliac Joints Lumbosacral Spine" which states:

The pelvis is intact. The sacroiliac joints are normal. Slight degenerative change is evident in the right hip joint.

There is extensive atheromatous calcification present in the aorta and iliac vessels which appear non aneurysmal.

The lumbar vertebrae are normally aligned. Disc spaces are maintained. Facet joints are articulate normally. There are no fractures or areas of bone destruction present.

IMPRESSION: Mild right hip osteoarthritis without other abnormality.
[Emphasis added.]

- (b) An x-ray report dated July 19, 2000 by Dr. Sherlock numbered 2606-0019/0020 entitled, "Pelvis, Bilateral Hips, and Sacroiliac Joints" which states:

The pelvis is intact. The sacrum and sacroiliac joints are normal. The symphysis is unremarkable.

There is minimal degenerative change present in the left hip.

There is considerable acetabular irregularity on the right with subchondral sclerosis apparent. The actual femoral head appears

relatively normal. Similar changes are present on the left but are less marked. There is slight joint space narrowing present on the right.
[Emphasis added.]

- (c) Also entered as Exhibit 3 is an “Addendum Report” numbered 2606-0019/0020 entitled, “Pelvis, Bilateral Hips, and Sacroiliac Joints” and dated July 28, 2000 by Dr. Keenan which states:

Comparison has been made with all available prior studies.

There is some focal cortical irregularity and a small focal cortical defect seen in the far superolateral aspect of the acetabulum, as previously described, with mild adjacent subchondral sclerosis.

These findings are essentially unchanged from prior radiographs dating back to 1998 and are likely of no clinical significance, possibly relating to old trauma. The joint spaces are well maintained with no evidence of any arthritic change.

There is no evidence of any avascular necrosis. There is a small amount of focal ossification seen in the soft tissues below the right ischium and right pubic ramus, also likely related to old trauma. The sacroiliac joints are within normal limits. Some focal ossification projects just above the left greater trochanter, which is also present on prior studies and measure less than 1 cm, again likely related to prior trauma. There has been no significant change from prior studies.

A handwritten note signed by Dr. Skinner at the bottom of this Exhibit 3 states:

As you know, the hip x-rays of June 26/00 were reported by Dr. Sherlock as showing, “considerable acetabular irregularity on the right with subchondral sclerosis apparent.”

I sent the films back with films of 1998 (we have no pre-injury films) for comparison and Dr. Keenan here reports more specific changes stating three areas that ‘changes are likely related to prior trauma.’ [The worker] has had no prior injury/trauma.

These findings are termed “post-traumatic degenerative joint disease and are consistent with injuries of his nature. They also are consistent as cause of ongoing weight bearing pain that is worsening as the joint degenerates.

The Worker's Testimony

- (80) The worker says that at the time of his accident he had worked for 12 years with the same employer as a heavy equipment operator.
- (81) The worker says that his job required him to be able to operate five different pieces of equipment: snow blower in the winter; grader; tractor-trailer moving the equipment; loader; and, gravel truck.
- (82) The worker says that as part of his job he was responsible for maintenance of the vehicles. All heavy equipment operators are issued a heavy equipment toolbox. With respect to the grader this involved changing the blades. The first blade weighed 80 to 90 pounds and the second blade is 55 pounds. The worker says that he also had to change the bucket on the loader to either a straight edge bucket or a bucket with teeth. Each of tooth weighs 48 pounds.

As part of routine maintenance he also changed the alternator in the engine of a vehicle when it broke. Although he is not qualified as a welder, the worker has also done some minor welding. Additional job duties included painting, helping in the ditch with putting up signs, icing off signs and washing signs.

He was also responsible for changing and fixing tires on all vehicles and greasing and changing oil as needed. He was also responsible for changing oil on the snow blower and the truck as well as on the grader. It was very difficult to do this on the grader because he had to balance himself on two tires in order to reach into the oil change area. He also had to climb on top of vehicles to change the lights. He says heavy equipment operators were required to do just about everything unless it was a major, major mechanical deal on steering where a mechanic would come from Whitehorse.

- (83) The worker says that before his accident and injury of October 2, 1997, he was able to do all the various aspects of maintenance and servicing on the vehicles he was required to operate as part of his job. He says that he had no problems in doing his job. He says he remembers when co-workers complained about sore backs he would always reply, "tap on wood" because he never had any trouble with his back.
- (84) The worker says that before his injury he had many outdoor physical activities such as skidooring, ice fishing (with a boat that he owned), and four-wheeling. He also says that he loved dancing and would come into Whitehorse every Friday night to do this. He also had a trap line. However, since the accident the four-wheeler remains parked in his yard and he has transferred his trap line to another trapper.

He says his only activities now are sitting around the house and eating. He says he can also do a little fishing.

- (85) The worker says that his wife has just finished building a greenhouse but that because of his disability he could not help her. He says he used to love to help around the house and he is “ashamed” that he can’t do it now.
- (86) The worker says that he has diabetes and sleep apnea; both of these conditions occurred before his injury. He says that he received a mask from a specialist in Vancouver that cured his sleep apnea prior to the injury.
- (87) The worker says he is a recovered alcoholic and drug addict. He has been clean for 15 years and he hasn’t smoked since 1977.
- (88) The worker says that at the time of the accident he was stockpiling gravel to mix with calcium. He says he was working in a rough pit into which they were hauling the gravel. He says at the time of the accident he was operating a 988 Cat Loader. There are five steps to the deck of the loader where the worker enters the vehicle. The worker says the accident occurred when he stepped out onto the deck of the loader which is approximately 6 _ to 7 _ feet above the ground and went to put his foot on the step immediately below the deck to climb down out of the vehicle. He missed the step and fell the remaining distance to the ground.
- (89) He says that immediately after the accident he was entirely unable to breathe. He says that he crawled to the tire of the vehicle on all fours and that was where his “buddy” helped him to stand up. He says that he said to his co-worker at the time, “Don’t touch me, I think I’m dead.”
- (90) The worker says that after the accident he did two more loads and tried to keep working. But then on the third trip he had to pull out of the truck. He says that this accident happened at the worst time because it was the last week of work before he was to go on a planned two-week holiday in Asia. Because of the accident, he was unable to go on his holiday.
- (91) The worker says that at the time of his accident he weighed 356 pounds. He says that before the accident he had weight training equipment which he used regularly. He says that currently he weighs 320 pounds and is still trying to bring his weight down.

- (92) The worker says that before his accident his weight had never bothered him. He says that people used to say, “How can somebody so heavy dance, without having any problems?”
- (93) The worker says that on the day of the hearing he would describe his pain, on a scale from one to ten, as 7 _ to 8. He says that he should have used his cane at the beginning of the hearing and that [by mid-afternoon] he is paying the price for not doing so. He says he also should have taken more painkillers at one o’clock during the hearing but he decided not to because had he done so he would have been impaired for driving home to his community.
- (94) The worker says that after his October 1997 injury, his Class 1 driver’s license which he had for 17 years was taken away from him as was his pilot’s license. He says he had to fight to keep a Class 5 driver’s license and that this license was initially denied on the basis of his pain medication. He says that Dr. F. stepped in (with the motor vehicle staff) to assure them that the worker could be trusted not to drive if he had taken drugs such as morphon which could lead to impairment of his driving ability.
- (95) The worker says that he needs a Class 1 license in order to do his former job: an annual medical is required to maintain this license. The Motor Vehicle Branch told him not to bother applying because his application for a Class 1 license would be denied on the basis of his pain medication.
- (96) The worker says that his difficulties with his leg involve his right leg giving out on him. This happened twice in Vancouver on the weekend just prior to the hearing. He was saved from falling down 17 steps at the Wal-Mart building by a friend who was standing beside him when his leg buckled. Usually he puts his left leg out first on stairs because if he uses his right leg on the top of a stair, it will kick out on him.
- (97) The worker says that for the past three months he has been for a drug called morphon for pain which he takes along with Gabapentin. He says the Gabapentin leads to constipation and he needs to take it with Metamucil.
- (98) The worker says that although he has a medical plan, for all prescription drugs he must pay the first 15% of the cost himself; the Metamucil is not covered (non-prescription). The worker says that 90 Gabapentin tablets cost him \$60.00 after the amount which is paid by the government insurance plan. He says he takes no less than six of these a day. He says he takes six milligrams of the morphon three times a day.

- (99) The worker says that before his accident he had an excellent work record. He was rarely off work for any type of injury or illness. For instance, he says that when he was working with White Pass he broke his foot and his arm on a Friday evening and then on Tuesday he was back at work in a cast. He says another time a compressor knocked him in the mouth and knocked some of his teeth out on a Thursday. He went to Whitehorse to have his teeth put back in and then he was back on the job on Monday. He says that he has always been lucky that he can hold more pain than the normal person. He always knew he could have taken time off and been paid for it, but he would rather work.
- (100) The worker says he does not want to have to go on welfare. He does not want to have to beg for this. The worker says he is now living on his savings. He has bought a house in a community outside of Whitehorse because housing is cheaper there than in Whitehorse. But at the rate he is spending his savings he might have to give up his home and move out to Salmon Lake where he has a cabin. However, it is difficult for him at Salmon Lake because the road has to be kept up and wood has to be cut for heat and he cannot do any of these things now.

Dr. Skinner's Testimony

- (101) Before giving his evidence Dr. Skinner was qualified as a general medical practitioner with a special practice interest and focus in pain assessment and management, and diagnosis. His qualifications are as follows:
- (i) seventy-five percent of his clinic practice patients are being treated with respect to chronic pain assessment and management;
 - (ii) board adjudicators often refer patients experiencing pain to him, apparently on the advice of the WCB medical consultants;
 - (iii) lawyers in Whitehorse also refer pain patients to him, usually after automobile accidents, for assessments and medical/legal opinion reports;
 - (iv) he is a member of the International Association for the Study of Pain, an international association of physicians doing research in pain or with a focus in their clinical practice on pain;
 - (v) he attends the Association's world congress every three years - - last year in Vienna (6000 physicians attending) and 5 years ago in Vancouver (4000 attendees);
 - (vi) he has attended many workshops including international ones dealing with pain medicine, the latest one in the spring of 2000 in Vancouver, a World

Congress on Whiplash jointly sponsored by the University of British Columbia, the Physical Medicine and Research Foundation and ICBC, the auto insurers of British Columbia;

- (vii) six years ago he attended a 200-hour course at the University of California Medical School, Department of Anaesthesia, in medical acupuncture for physicians;
- (viii) he works approximately 25 hours a week in the Emergency Department at Whitehorse General Hospital where many patients present with acute pain.

On the basis of the training and experience set out above, the appeal committee has determined that Dr. Skinner's evidence as an expert is necessary to provide the appeal committee with information which is outside of its knowledge and experience as lay persons. In addition, Dr. Skinner is a treating physician for the worker and ordered the new x-rays (see Exhibit 6) as well as requested the comparison of 1998 and 2000 x-rays (see Exhibit 3).

- (102) Dr. Skinner says that the difference between chronic pain syndrome and myofascial trigger point pain syndrome is as follows:
- (a) Chronic pain syndrome is a very, very general term. It is so general that it covers absolutely everything. "Syndrome" is a collection or group of symptoms, and "chronic" refers to pain that is long-standing. Most people when they refer to chronic in terms of pain will refer to something lasting six months or more. Some chronic pain centres use a figure of three months, some even six weeks.
 - (b) Myofascial trigger point pain syndrome is much more specific. "Myofascial" refers to two tissues of the body – that is, muscle and ligament. Ligament joins bone to bone. Muscle also goes from bone to bone but it has a tendon between the muscle and the bone. "Trigger point" means a very sensitive part of muscle or ligament. It is sensitive because the sensory nerve there is hyperactive: almost as if it has an amplifier in it when touched or stimulated so that it signals a lot of pain that it otherwise would not.
- (103) Dr. Skinner says the worker's physical pain has actually been increasing the past two years and also his mental/emotional reaction to this persistent pain. He says the worker has understandably and appropriately lost his determination to go back to his [pre-injury] job. Dr. Skinner says this is appropriate because it is unrealistic given the amount of disability he has because of his pain [for the worker to return to his former job].

- (104) He says the worker can no longer climb the 6 feet up into his grader with the disability his degree of pain causes. However, Dr. Skinner says the worker is certainly still determined to get well. He says he has never seen the worker in a passive state; he remains quite a fighter.
- (105) Dr. Skinner says the worker does as much as he can to keep busy and occupied so that his mind is off his pain.
- (106) Dr. Skinner says he ordered the x-rays on June 26, 2000 of the worker's pelvis, both hips, and his sacroiliac joint because his pain was not decreasing but increasing; in addition, the worker described more severe pain on the right side during weight bearing. Dr. Skinner says this led him to suspect that there may have been some changes which would show up on x-rays.
- (107) Dr. Skinner says a radiologist, Dr. S., read the x-rays and his report basically says the pelvis sacrum and sacroiliac joints as well as the pubic bones are all normal.
- (108) Dr. Skinner points out that Dr. S. states: "There is minimal degenerative change present in the left hip." (Dr. Skinner says one would expect this change in any person of the worker's age.) Dr. S. also states: "There is considerable acetabular irregularity."
- (109) Dr. Skinner says the acetabulum is the cup part of the ball and cup configuration of the hip joint. He says there is considerable acetabular irregularity on the right hand [side] with subchondral sclerosis, that is, hardening under the cartilage that covers the bones and the joints. This hardening shows up on an x-ray as extra calcium. It is a sign of degeneration whereby the cartilage is wearing down and then the underlying bone builds up more calcium in an attempt to deal with the extra pressure on the joint surface at that site.
- (110) Dr. Skinner compares the next sentence, "similar changes are present on the left but are less marked" with the last sentence of Dr. S.'s report: "There is slight joint space narrowing present on the right."
- (111) Dr. Skinner says this difference would be expected [that is] because the space is greater [on the right] than on the left which is consistent with more degeneration [on the right].

- (112) Dr. Skinner says that because Dr. S. made no reference to previous x-rays, it was inadequate and so Dr. Skinner sent out all previous x-rays going back to 1998 of the worker's injuries. Dr. Skinner notes no prior injuries were reported so there were no x-rays prior to his workplace injury. He says the old 1998 x-rays were compared with the most recent x-rays by another radiologist, Dr. K., who finds "mild adjacent subchondral sclerosis" [on the right] which Dr. Skinner says Dr. K. relates to the old trauma.
- (113) Dr. Skinner says that the key finding in the x-ray reports is that there are more changes of degenerative joint disease on the right than on the left side of the sacroiliac joints. Dr. Skinner says that this difference is consistent with the fact that when the worker fell he landed with most of his weight on his right side. He says the x-rays are consistent with the fact that most of the worker's symptoms have been on the right and that it hurts him when he puts weight on the right hand side of his body but there is less pain when he puts traction [on his right leg] so that the ball is pulled out of the cup [in the hip joint on the right side]. He says the physiotherapist also pointed out early on that traction on this joint [on the right side] relieved a lot of the worker's pain.
- (114) Dr. Skinner says that he has no record of any injury to the worker's hips prior to his workplace fall in October 1997.
- (115) Dr. Skinner refers to Chapter 15, pages 305 to 306 of the Fourth Edition of the *AMA Guides to the Evaluation of Permanent Impairment*. He says he prefers the term "persistent pain." The term "chronic pain" is reserved for devastating persistent, recalcitrant, non-recovering type of pain with major psychosocial consequences. Chronic pain is persistent and is very destructive: it is considered to be "useless" pain in the sense that it is not there to protect the person from injuries such as burning or a cut or a break. It is also pain that is self-sustaining. It is not from an underlying sudden injury to the body, or a recent injury, but rather it is a longstanding phenomenon. Dr. Skinner says the *AMA Guides* makes the important point that it is the illness of the whole person not just the physical body or certain organs like the hip or the buttock that is important. Dr. Skinner says that the important statement in the *AMA Guides* with which he disagrees (as applied to this worker) is that people with chronic pain syndrome have very maladaptive psychological reactions and behaviours.
- (116) Dr. Skinner says the worker does not have maladaptive or disproportionate reactions to his pain: he says the worker tries to conceal his pain. He says he has seen the worker walking in public and has not heard him groan and moan.

- (117) Dr. Skinner paraphrases the *AMA Guides* as saying that with chronic pain syndrome the injured area heals but the person's reaction goes on as the abnormal pain behaviour. He says that when he physically examines the worker he always finds extreme physical sensitivity to pain the entire right hip area, buttocks, upper leg, and up that side of back.
- (118) Dr. Skinner says the worker has developed nerve injury pain: that is, the injured nerve continues to send pain signals even though it is not currently inflamed and that is called "neuropathic pain." The pain persists because the nerve itself has been injured. If an injury caused inflammation of the nerve, then the nerve itself becomes abnormal in its conduction; it becomes abnormal in its nerve chemicals or nerve transmitters and it continues to send pain even though there is nothing there.
- (119) Dr. Skinner says these changes have been shown in studies in the *Journal of Pain*, which is the world authority. He says it has been decades now that [researchers] have shown changes in the nerve and in the spinal cord. These changes perpetuate pain without stimulus out in the muscle. He says that he believes the worker is suffering this now: that is, even though the muscles and ligaments have settled down, the worker has persistent neuropathic pain.
- (120) Dr. Skinner says that degenerative changes in his hip are very minor, though important, in terms of giving the worker pain. If the worker's nerves had not been injured to the degree they have, the joint pain would not be magnified by the nerve. Dr. Skinner says the worker has a separate entity [beyond degenerative changes] known as neuropathic pain. Dr. Skinner says it is like the worker's nerves in the injured area have amplifiers on them sending far more pain. The nerve itself is a pain generator.
- (121) Dr. Skinner says that his disagreement with the medical consultant is that the worker does not have maladaptive behaviour: he does not live on his emotional, mental aspects to pain. He says with the worker it is the opposite behaviour - - pushing his body to the limits he can tolerate with pain.
- (122) Dr. Skinner says he therefore disagrees with the term chronic pain syndrome [being applied to the worker] who has persistent work injury related pain. The worker's pain involves the nerves themselves and whatever degree of post-traumatic degeneration that is occurring in the joints.

- (123) Dr. Skinner says proof of neurochemical or nerve conduction changes can be shown by doing biopsies and light and electron microscopic studies of the tissues in the muscle and nerve or muscle ligaments. Laboratory studies show that persons with persistent pain have high levels of pain hormones in the region of the injury and also high in the spinal fluid. However, that detection is done in the research lab not in hospital laboratories or in regular daily medicine.
- (124) Dr. Skinner says that he has prescribed an anti-convulsive drug for the worker's pain. This drug came to be used as an analgesic because it stopped, to a degree, the spontaneous firing of nerves for many people with epilepsy. Nerves that were irritable, hypersensitive, short-circuiting, firing off, and causing seizures - - the drug was found to help control this. It was found that epileptics who had pain disorder also had less pain when they were taking this drug. The drug is now used far more as an analgesic [pain reliever] for people suffering persistent pain, (that is neuropathic pain, nerve injury pain) than it is for epileptics.
- (125) Dr. Skinner reviews the diagnostic characteristics for chronic pain in the *AMA Guides* with respect to the worker. He says that in his view the worker does not exhibit the characteristics except for the first one with respect to "duration" of pain. He says that:
- (a) the worker does not dramatize his pain;
 - (b) as a doctor he has no diagnostic dilemma with respect to the worker's symptoms (it is very straight forward - - the worker has had injuries which have resulted in persistent pain);
 - (c) there has been no problem with drug use;
 - (d) the worker is not dependent nor does he demand excessive care;
 - (e) his coping mechanisms are very strong rather than severely impaired and he suffers appropriate loss of self-esteem - - he cannot now be the main wage provider for his family;
 - (f) with respect to "disuse" as a diagnostic characteristic, Dr. Skinner says the worker will experience as much pain as he can stand before he will ask [for help] - - he says the worker does not immobilize himself because of pain for any secondary gain (he does his daily walks and he forces himself to get out on his boat and fish and he walks in the bush);
 - (g) with respect "dysfunction", Dr. Skinner says he has not seen the worker become socially reclusive or drop recreational endeavours - - he does what he can. He says he has seen the worker in social settings briefly: the worker is not bereft of social contacts.

For all these reasons, Dr. Skinner says the worker does not fit the diagnostic characteristics for chronic pain syndrome.

- (126) Dr. Skinner says the worker is disabled from operating heavy equipment because of his pain.

The Workers' Advocate Submissions

- (127) The workers' advocate submits that Policy CS-01, "Treatment" was incorrectly applied to the worker.
- (128) The workers' advocate submits that Policy CS-01 must be interpreted in a manner that is consistent with the entitlement provisions of the *Act*. Specifically section 3.(1) which states:

Eligibility for compensation

- 3.(1)** A worker who suffers a work-related disability is entitled to compensation unless the disability is attributable to conduct deliberately undertaken for the purpose of receiving compensation.

He says there is no provision in the *Act* for a limitation on the compensability of work-related disability based on a particular diagnosis. But he says that is what happened to the worker: the diagnosis of chronic pain/chronic pain syndrome by the medical consultant [December 14, 1998] led to a referral for 6 weeks of treatment [February and March 1999] in a pain management program and then an adjudicator's letter in April 1999 stating that the board "does not recognize chronic pain as a disability for entitlement purposes."

- (129) The workers' advocate points out that in the "section reference" of Policy CS-01, there is no reference to Section 3 of the *Act*. He says this omission is consistent with his interpretation of Policy CS-01 - - that is, CS-01 must not be interpreted to limit treatment of a work-related disability: it can only be used to limit treatment of a "condition" which is unrelated to a compensable injury and which also "delays or hinders the recovery of a worker who has suffered a work-related disability."
- (130) In addition, the workers' advocate submits that Policy CS-01 itself makes this distinction clear in section D as follows:
Upon completion of treatment, the disabled worker shall not be eligible for any additional benefits beyond those the worker may be entitled to receive as a result of the work-related disability.

- (131) To illustrate the distinction between a condition that is not work-related but may hinder a worker's recovery from a work-related disability versus a condition which results in a work related disability, the workers' advocate refers to page 47 of Terence Ison's book, Workers' Compensation in Canada (2nd ed.), where the author discusses alcoholism as follows:

There would seem to be no reason in principle why alcoholism should not be compensable, but there is an obvious reluctance. In a case involving a miner who was alleged to have become an alcoholic in a mining camp, the Board declined to recognize alcoholism as an industrial disease. However, it is difficult to see how the same view could be taken in a case that is stronger on the facts; for example, a brewery worker who is supplied with unlimited free beer by the employer and encouraged or permitted to drink it on the premises of the employment.

[We note that although Ison does discuss compensability of alcoholism if work-related, he does not deal with the case of pre-existing alcoholism which is not work-related. Policy CS-01 deals with "treatment" of "conditions" which "hinder a worker's recovery from a work-related disability": the policy says such conditions include but are not limited to alcoholism, drug addiction, and chronic pain.]

- (132) The worker's advocate also gives the example of two scenarios with respect to a worker who has a drug addiction. In one scenario the worker has a drug addiction prior to and at the time of a work-related disability. In this case, under a correct application of Policy CS-01, the drug addiction – if it hindered the worker's recovery from the work-related disability – would be treated for a period up to six weeks. Such treatment would not limit the treatment or compensability of the work-related disability. In the second scenario the worker suffers a work-related disability and as a result of the treatment of this injury becomes addicted to prescription narcotics. In this case, treatment for the worker's drug addiction would be fully covered if it were linked to and a direct result of the work-related disability, rather than limited to a six week treatment period under Policy CS-01. In other words, the workers' advocate submits that Policy CS-01 would not apply to the worker in the second scenario.
- (133) The workers' advocate submits that the same reasoning should apply to work-related disabilities which are caused by conditions – including those involving chronic or persistent pain – which arise out of or in the course of employment.

(134) The workers' advocate says that of all the medical personnel who have assessed and treated the worker, only the medical consultant has given a diagnosis of "chronic pain syndrome." This diagnosis then led to an adjudicator's decision to terminate compensation and medical services to the worker. The workers' advocate says that this decision was made on the basis of an incorrect interpretation of Policy CS-01. That is, the adjudicator incorrectly interpreted Policy CS-01 to mean that the board does not recognize chronic pain as a disability; and therefore, the worker, by virtue of his diagnosis, was no longer entitled to any compensation even though he had not recovered from his disability.

(135) The workers' advocate submits that the evidence with respect to this worker's condition meets the definition of disability in section 101 of the *Act* as follows:
"disability in respect of a worker means a work-related incapacity, as determined by the board, including post-traumatic stress, a permanent impairment, or a worker's death.

He submits that the words "as determined by the board" refer to the board's authority to administratively assess disability in accordance with Policy CL-40, "Disability."

That policy defines disability as "the limiting, loss or absence of the capacity of an individual to meet occupational demands."

(136) The workers' advocate submits that there is evidence of disability from:

- the worker's treating physician [see paragraphs 33 and 126];
- the March 1999 report from the Columbia Rehabilitation Centre [see paragraph 63];
- the December 1998 Voc-Aid report [see paragraph 53]; and,
- the Functional Capacity Evaluation Summary Report dated November 5, 1998 [see paragraph 50].

(137) The workers' advocate submits that there is extensive evidence

- a) that the worker suffers from myofascial pain syndrome;
- b) that the worker suffers from right hip pathology (see most recent medical evidence); and,
- c) that both (a) and (b) arose out of and in the course of the worker's employment.

The workers' advocate submits that on the basis of this evidence, the worker is entitled to compensation under the *Act*. [Note: We will discuss this evidence in the analysis section of this document.]

- (138) Lastly, the workers' advocate submits that there is no evidence that the pre-existing conditions of the worker - - diabetes, hypertension, or obesity - - had in any way incapacitated the worker from meeting the occupational demands of his job as a heavy equipment operator prior to the workplace fall and resultant injury on October 2, 1997. In addition, the workers' advocate points to the neurologist's conclusion of April 2, 1998 where Dr. S. states there is no evidence of the diabetic neuropathy as a cause of the worker's symptoms: Dr. S. instead attributes causation in terms of the worker's symptoms to the injury on October 2, 1997 as follows: "this man presents with significant complaints of pain following an injury on October 2, 1997. I agree with previous opinions that he most likely has sustained a significant musculoskeletal injury with resultant myofascial pain syndrome." [Emphasis added.]

Issues

The appeal committee has determined the issues are as follows.

1. What legislation should be used to determine the worker's entitlement in this case and what policies are applicable?
2. Is the worker entitled to compensation including wage loss, medical aid and rehabilitation services?

Analysis on Issue #1 What legislation should be used to determine the worker's entitlement in this case and what policies are applicable?

The worker was injured in a workplace accident on October 2, 1997. Section 90 of the current *Act*, the "transitional provision," states "where a worker is entitled to compensation as a result of a disability in . . . March 31, 2000 or earlier, the worker's entitlement to compensation shall be determined pursuant to predecessor legislation as it was in force before April 1, 2000." Therefore, we find that the *Workers' Compensation Act*, S.Y. 1992 as amended up to the date of the injury in 1997 is the legislation to be used to determine the issues of entitlement in this case.

First, we find that sections 3.(1) and 5 of the *Act* are relevant to our decision in this case.

Section 3.(1) states, “A worker who suffers a work-related disability is entitled to compensation unless the disability is attributable to conduct deliberately undertaken for the purpose of receiving compensation.”

Section 5 states, “Where a disability arises out of or in the course of a worker’s employment, the disability is presumed to be work-related unless the contrary is shown.”

We also find that two definitions found in section 101.(1) of the *Act* are relevant to the determination of the issues in this case. They are as follows:

“ ‘disability’ in respect of a worker means a work-related incapacity, as determined by the board, including post-traumatic stress, a permanent impairment, or a worker’s death.”

“ ‘work-related’ in reference to a disability of a worker means a disability arising out of and in the course of the employment of a worker.”

Policies have been passed by Yukon Workers’ Compensation Health and Safety Board to give meaning and effect to the words of these particular statutory sections. Accordingly, we further find that Policy CL-40 entitled “Disability” applies: this policy lists as its section reference, section 101.(1).

This policy states: “if a worker suffers an injury or illness that arose out of or in the course of their employment, they are entitled to compensation. This includes wage loss benefits if the injury/illness has caused them to miss work.”

The policy also states: “the term ‘disability’ is used in determining whether someone is eligible for wage loss reimbursement or retraining, and relates specifically to the worker’s capacity to meet the demands of the job.”

As well, the policy defines disability as “the limiting, loss or absence of the capacity of an individual to meet occupational demands” and says that disability is “an administrative finding assessed by non-medical means.”

Without a “disability” there is no entitlement.

Therefore, we first turn to the evidence with respect to the worker’s capacity or incapacity to meet occupational requirements. We find that this worker does have a disability, based on our consideration of the evidence from both his record and the hearing.

In particular, we accept and rely on the March 1999 report from the Columbia Rehabilitation Centre which states at page 17 that the worker “is medically advised to avoid work requiring ladder climbing, frequent bending, and awkward positions. He is also advised to avoid prolonged sitting, standing, or walking over irregular surfaces for prolonged periods. This report also concluded that the worker was considered to be functioning at a sedentary level.

We accept the worker's testimony with respect to the duties of his pre-injury job as a heavy equipment operator as set out at paragraphs 81-82 of this decision. It is clear his work did require ladder climbing, frequent bending and awkward positions. We also note that in Exhibit 1 "Yukon Futures," the working conditions of heavy equipment operators are described as follows: "These workers should be physically fit and able to adapt to rugged working conditions. Mechanical dexterity and comfort with computerized equipment is necessary. An aptitude for mechanical repairs and maintenance is helpful. . . Workers employed in this occupational group should be prepared to work in noisy, dusty and dirty environments in almost any kind of weather. . . . Those who operate excavating and grading equipment have to sit for long periods of time on vibrating or bouncing machinery."

Our finding that the worker has a disability - - in terms of a limited or lost capacity to meet the occupational demands of his pre-injury job - - is also based on:

- the assessments reported in the Voc-Aid report of December 1998 which sets out at page 2 restrictions on the worker "for lifting, carrying, standing and walking activities" as well as restrictions in "postural abilities" such as "climbing, balancing, stooping, kneeling, and crouching" which are "limited due to back pain,"; and,
- the Functional Capacities Summary Report dated November 5, 1998 which compares the worker's abilities to the activities demanded by his occupation as heavy equipment operator and concludes that he "would not be able to safely perform his work duties as a heavy equipment operator at the present time."

Next, we must consider whether the worker's disability is "work-related." If it is not, it is not compensable under the *Act*. As section 5 and the definition in section 101.(1) make clear, "work-related" means "arising out of and (or) in the course of employment."

We find that the worker's disability is work-related. In coming to this conclusion, we have applied Policy CL-42 which provides guidelines for determining whether or not a disability arose out of and in the course of employment. In this regard we find that the the disability occurred on the premises of the employer; the worker was required to be there by the employer; the disability occurred in the normal course of the worker's duties; the disability occurred in the course of using equipment or materials supplied by the employer; the disability occurred in the process of doing something for the benefit of the employer; and the disability occurred during a time period for which the worker was being paid. We find that the worker was on the job stockpiling gravel with a loader when he fell from the deck of this vehicle as he was exiting it and injured himself. Virtually all the medical opinions link the worker's current disability [that is, his incapacity to do the job of heavy equipment operator due to pain, reduced range of motion, loss of power to his right leg and restrictions in his ability to sit/stand/walk for prolonged periods, etc.] to the fall from his loader on October 2, 1997.

These opinions are as follows:

- the February 17, 1998 of Dr. S., orthopaedic surgeon stating: “This patient has not medical history of relevant injuries to his low back, hip and coccyx. From an orthopaedic standpoint, his findings are all compatible with the above diagnostic condition [i.e., lumbar sprain/strain; lumbar facet syndrome (due to jamming force as he fell); right trochanteric bursitis; fractured coccyx]. In my opinion his current condition is entirely a result of the specific industrial injury on 10/03/97 while employed with [the employer].”
- the medical consultant’s report dated March 9, 1998 which states that “the small annular tear at the L5-S1 level [as imaged in the February 17, 1998 MRI] may well have occurred from the fall.”
- the report of neurologist, Dr. S., dated April 2, 1998 which states: “this man presents with significant complaints of pain following on injury on October 2, 1997. I agree with previous opinions that he most likely has sustained a significant musculoskeletal injury with resultant myofascial pain syndrome . . . I feel that his symptoms of bladder and bowel urgency as well as sexual dysfunction are most likely nonspecific effects of the injury and severe pain that he is experiencing. [This doctor also notes that the severity of the worker’s pain syndrome most likely relates to his obesity but not to his diabetes.]
- the report of Dr. M., orthopaedic surgeon, who states in his report of May 1, 1998 that the worker’s “current problems are stemming more likely from contusional injuries to the soft tissues in the vicinity of the hip.” [Note: contusion (bruise) was the diagnosis immediately after the fall in the doctor’s first report dated October 3, 1997 - - “bruised coccyx.”]
- Dr. Skinner’s letter of February 1, 1999 to the medical consultant which states the worker “has persistent pain from trauma to the right lower trunk which most significantly involves the hip joint at this point in time. [Note: in the context of this letter, it is clear that the “trauma” referred to is the October 2, 1997 injury.]
- Dr. Skinner’s February 1, 1999 letter to the Columbia Rehabilitation Centre which states: “this man received far more than a ‘coccygeal contusion’. Given his weight and fall of 6 feet onto icy ground, he contused far more than his tailbone. In fact, the lumbosacral nerve plexus injury resulted in a period of urinary incontinence and impotence . . . He had no prior injury and I interpret [the] small annular tear [at L5-S1 on the MRI] and disc dessication as indicative of his traumatic fall . . . His soft tissue pain remained widespread in the region of the right hip girdle extending up the loin, as well as down the right leg. Most particularly, he experiences his maximum pain on weight bearing with the right hip where he experiences a clicking sensation which is palpable by an examiner and, at times, grossly audible and always associated with severe lancinating pain. At times this results in an instant reflex loss of leg motor power causing him to

fall. . . [H]is persistent weight bearing hip joint/capsular pain has resulted in development of persistent post-traumatic myofascial trigger point pain syndrome of the hip girdle . . . [T]he persistent severe pain on weight bearing . . . is indicative of pathology of the hip joint and capsule per se.”

- the opinion provided in the hearing by Dr. Skinner with respect to the most recent x-rays and interpretations (Exhibits 3 and 6) which Dr. Skinner says show degenerative changes in the right hip area which he finds are consistent with the trauma of the worker’s 1997 workplace fall onto the right side of his body.

We note that although the medical consultant states in his December 22, 1998 report that he “can find no objective evidence of neurologic or orthopedic disorder” at no point does he state that his diagnosis of chronic pain/chronic pain syndrome is unrelated to the initial injury on October 2, 1997.

The medical consultant does, however, state: “at this point, I can find no objective evidence of a permanent impairment of function as a result of the injury sustained in October of 1997. At present the primary limiting factor is pain.”

Policy CS-01 Analysis

The crux of this case is the proper interpretation of Policy CS-01. As we will explain, we disagree with the IRC’s interpretation of this policy.

In the decision now under appeal, the IRC concluded that “the only factor keeping the worker from returning to employment is his persistent pain.” [We note that the IRC seems to equate the term “persistent pain” with “chronic pain”: however, the *AMA Guides* in Chapter 15 at page 306 distinguish these terms in this way: “persistent pain may exist in the absence of chronic pain, but chronic pain always presumes the presence of persistent pain . . . Pain of long duration is properly referred to as ‘persistent pain,’ with the term ‘chronic pain’ being reserved for the devastating and recalcitrant type with major psycho-social consequences.”]

Dr. Skinner has given evidence, which we accept, that this worker does not have chronic pain or chronic pain syndrome but rather a more specific diagnosis of myofascial pain syndrome. In addition, this diagnosis is confirmed by others. So is his diagnosis of right hip joint pathology which we also accept. In this regard we prefer his opinion and diagnosis over that of the medical consultant because of Dr. Skinner's extensive experience in dealing with patients with pain; his many opportunities to examine the worker; and the completeness and accuracy of his reports and the relevant facts on which they are based - - in particular, we note his attention to the palpable and sometimes auditory click on examination in the worker's right hip area and his deductions with respect to reduced pain in right hip area with traction.

While we do note that he indicated in a letter a strong disagreement with board policy and treatment of patients with persistent pain, we are satisfied that this disagreement does not impair his objectivity with respect to diagnosis and assessment in this case.

We also point out that the IRC 's conclusion -- that the only factor keeping the worker from returning to work was persistent pain -- was made without the benefit of new medical evidence of degenerative changes based on X-ray reports presented at the hearing (see paragraph 79). These degenerative changes were attributed to trauma. Dr. Skinner stated in his evidence that the greater degenerative changes on the right side as shown in these X-rays were consistent with the original workplace injury. In other words, because the X-rays showed more degenerative changes on the right side of the worker's body than on the left and because the worker experienced a significant workplace fall onto his right side, it is more likely than not that the greater degree of degenerative changes on the right side is due to the trauma of the workplace injury, which occurred three years ago.

We find this to be a reasonable hypothesis and accept Dr. Skinner's evidence in this regard. Therefore, it follows that we disagree with the IRC's finding at page 8 of its decision that the worker "has had repeated radiological investigations which have not indicated a work-related pathology for his continuing pain."

We also reject the IRC's conclusion at page 9 that "there are certainly pre-accident factors that might be involved, such as diabetes." With respect to the worker's diabetes, we accept the neurologist's conclusion of April 2, 1998 that there is no evidence of a diabetic neuropathy as a cause of the worker's symptoms [see paragraph 23]. The only pre-existing condition which we find is a possible factor in the original injury is the worker's obesity (see paragraph 23). However, we find that this condition does not alter our finding that this worker's disability arose out of and in the course of his employment: it is not relevant to the worker's entitlement that a person who was not obese would perhaps have been less injured in a similar fall. Also, we accept the worker's evidence that his weight had not interfered with his ability to meet his pre-injury occupational demands.

There is also evidence, which we accept, that beyond simply persistent pain, there are other symptoms which result in a loss of the worker's capacity to perform his pre-injury job: for example, the sudden loss of motor power he has experienced in his right leg, resulting in falls and near-falls as well as the bladder and bowel incontinence problems that occurred twice post-injury (see paragraph 23) and had never been experienced by the worker pre-injury. We find that it is more likely than not that these symptoms are also linked to the workplace injury. As well, as we pointed out earlier, we find that there are work-related degenerative changes. In addition, there are limitations on the worker's range of motion, postural abilities, etc. (see page 39). It is difficult to say how much of the latter are the results of pain, deconditioning, or degenerative changes. In any case, in our view, they are all linked to the workplace injury which arose out of and in the course of the worker's employment.

Lastly, in our view the IRC incorrectly interpreted Policy CS-01 when it stated at page 9 of its decision:

Board Policy CS-01 does not consider the origin of chronic pain or a chronic pain disorder. The policy merely allows the board to treat the problem for a period of up to six weeks if it is hindering a return to work. The policy clearly states that no further benefits are payable due to the condition after treatment. Suggesting that the pain is a symptom of a neurological abnormality does not circumvent the policy.

We note that in its Conclusion at page 9, the IRC states that the workers' advocate "could be right in her assertion that the pain is work-related. . . ." Unlike the IRC, we find that a decision as to whether Policy CS-01 applies to a particular case requires an analysis of the origin of a worker's chronic or persistent pain. We will explain why by looking more closely at Policy CS-01.

In our view, Policy CS-01 makes a clear distinction between "conditions" which hinder recovery and "work-related disabilities." These terms are not used interchangeably in the policy. The policy does not say that if illnesses or injuries such as alcoholism, drug addiction or chronic pain arise out of and in the course of employment and limit the capacity of the worker to meet occupational demands, treatment is limited to six weeks. [As it is not necessary to our decision in this case, we need not determine whether or not if the policy did so, such a policy (a) would exceed the authority of the board, given the broad entitlement of section 3 of the Act or (b) would be unconstitutional under an analysis of the application of the *Charter's* equality guarantee in section 15 and the saving provision in section 1 of the *Canadian Charter of Rights and Freedoms* as well as (c) the ability of the tribunal to apply the *Charter*, etc.]

We further note that Policy CS-01 makes no reference to section 3 of the Act which deals with entitlement to compensation with respect to work-related disabilities.

We also note that in section D of Policy CS-01, it clearly states that treatment of a condition under the policy cannot alter entitlement for a work-related disability as follows:

Upon completion of treatment, the disabled worker shall not be eligible for any additional benefits beyond those the worker may be entitled to receive as a result of the work-related disability.

In this case we have found that the worker's disability is the result of a workplace injury. Therefore it is compensable and Policy CS-01 does not alter the worker's entitlement. It does not apply because his persistent pain and other symptoms are not simply conditions which hinder recovery but rather are conditions that are inextricably part of the work-related disability itself.

We agree with the submissions of the worker's advocate's with respect to the proper interpretation of Policy CS-01 and found them helpful in our analysis of Issue # 1.

We also emphasize that there is a difference between interpreting policy and either creating it or refusing to apply it in situations where it is clearly relevant to the facts of a case. The appeal tribunal is required to apply policies set by the board; the tribunal must also make decisions on the merits and justice of the case. (See section 19.5 of the *Act*.) In this regard, the tribunal has exclusive jurisdiction to hear and determine all matters arising in respect of an appeal (see section 18.4(1)) including whether a worker's disability is work-related and whether a worker is entitled to compensation (see section 18.4 (2) (a) and (h)). The decisions of the tribunal are "final and conclusive" subject to a direction for re-hearing from the board (see section 18.4 (3) and 18.3 (8) of the *Act*, respectively). In our view, the *Act* gives the appeal tribunal the jurisdiction to make a decision about whether or not a policy applies as well as the jurisdiction to interpret policy. It is these jurisdictions that we are exercising in this case.

Analysis on Issue #2 Is the worker entitled to compensation including wage loss, medical aid and rehabilitation services?

It follows from our finding that the worker suffers from a work-related disability that he is entitled to:

- (i) any resulting wage loss;
- (ii) reimbursement for medical expenses incurred by him with respect to the work-related disability; and,
- (iii) the provision of rehabilitation services and medical aid as set out in the *Act*.

Conclusion

The appeal is allowed. The decision of the IRC is reversed and varied as follows:

1. Policy CS-01 does not apply to limit entitlement for the worker's work-related disability;
2. The board must pay compensation to the worker for his loss of earnings according to section 22 of the Act beginning from the date that the worker's re-employment assistance benefits were terminated.
3. The board must provide medical aid to the worker according to section 28 of the Act as well as reimbursement for medical expenses incurred by him with respect to the work-related disability.

4. The board must provide rehabilitation services to the worker according to section 30 of the Act.

Dated this **20th** day of **October, 2000** in the City of Whitehorse, in the Yukon Territory.

Jan Stick, Member

Heather MacFadgen, Presiding Officer

Karen Waroway, Member