

Workers' Compensation Appeal Tribunal

Decision #191

Claim No.: 3000-5263

Related Claim No.: 3000-2917

Date of Notice of Appeal: April 18, 2011

Date Notice of Appeal Received at Tribunal: May 9, 2011

Date of Oral Hearing: October 17, 2011

Date of Decision: December 2, 2011

**Appeal Committee Members appointed under s. 64 (1)
of the *Workers' Compensation Act*, S.Y. 2008, c. 12**

Committee Chair:	H. Leenders
Member representative of employers:	H. Hermanson
Member representative of workers:	M. McCullough

In attendance: The Worker
The worker's representative – Rebecca Anderson
Observer – Mark Hill
Recorder - Vernna Johanson

Location: 456 Range Road
Whitehorse, Yukon Territory

Introduction

The worker was employed as a paramedic. On October 21, 2009 he filed a Worker's Report of Injury/Illness with Yukon Workers' Compensation Health & Safety Board (the "board") stating he injured his lower back and right knee while pulling a patient up on a stair chair. He reported that he slipped backwards on the stairs, catching his right foot under the stair chair. The worker reported that he did not seek medical attention that day and did not miss work because of the injury.

On January 7, 2010 the worker contacted the board noting that he was going to take time off work due to the injury and had incurred medical costs. An adjudicator notified the work on January 19, 2010 that his claim did not meet the criteria in the legislation and she would not accept his claim for compensation.

The worker had a previous knee injury for which he filed a claim with the board in August of 2008; Claim No. 3000-2917. This claim was accepted by the board. He was provided time loss and medical benefits. This claim was closed on August 6, 2009 as the worker had returned to work with no ongoing medical requirements.

The Hearing Officer's Decision

The hearing officer rendered a decision on July 7, 2010 agreeing with the adjudicator's January 19, 2010 decision that the worker had a pre-existing condition in his right knee that was not work-related prior to the July 2008 incident. He found there was no indication that the pre-existing condition was aggravated or accelerated by the soft tissue sprain in October.

Decision

The worker's appeal is allowed. The hearing officer's July 7, 2010 decision is reversed.

Jurisdiction

- [1] On May 4, 2011 the workers' advocate office representing the worker, filed an appeal of the hearing officer's decision with the tribunal under s. 53 of the *Workers' Compensation Act*, S.Y. 2008. The review (appeal) must be determined according to the *Workers' Compensation Act*, S.Y. 2008, c. 12 (the *Act*). Section 65(1) of the *Act* gives the appeal tribunal jurisdiction to hear and decide this appeal.
- [2] Compensation entitlement decisions are made pursuant to legislation in place at the time of injury. The worker filed a claim for an injury which occurred on October 21, 2009. In this instance the *Workers' Compensation Act*, S.Y. 2008 as amended to the date of injury should be used to determine issues of entitlement.
- [3] The board provided the following policies to the tribunal as relevant to this appeal under the authority of section 64 (4) of the 2008 *Act*:

- Policy EN-02, Merits and Justice of the Case
- Policy EN-07, Pre-existing Conditions

[4] The worker attended the hearing and testified by affirmation. He was represented by the deputy workers' advocate. The proceedings were recorded.

[5] The appeal committee considered the following:

- the worker's testimony
- the workers' advocate's submission
- the aforementioned policies
- the entire claim record No. 3000-5263 and 3000-2917 as provided by the board.

Preliminary Matters

[6] Further medical reporting was submitted as follows:

1. Initial Assessment Report dated April 8, 2011 by a physiotherapist
2. Consultation Report dated June 1, 2011 by an orthopaedic surgeon

On August 16, 2011 a board hearing officer advanced a letter to the tribunal listing the above documents, stating the tribunal is required to determine whether the information is new evidence according to Policy AP-03, "New Evidence at Reviews & Appeals." The hearing officer then "submits" the above information is not new evidence in that it is not remarkably different from information that was before the hearing officer.

The appeal committee reviewed the documents and determined they did not fit the criteria for new evidence as contained in Policy AP-03, New Evidence at Reviews & Appeals.

Background and Evidence

We will be referring to medical professionals by initial only in order to maintain confidentiality.

Claim No. 3000-5263

[7] The Worker's Report of Injury/Illness dated October 21, 2009 states the worker injured his right knee and lower back at work when he slipped on a stair while pulling a patient backwards up the stairs on a stair chair. His right foot caught under the stair chair.

[8] The worker attended Dr. A., general practitioner, on November 19, 2009. Dr. A. diagnoses a sprained knee. Objective findings indicate there is pain in the medial right joint with range of motion, while pivoting to the left on the right foot. No swelling is noted and there is normal range of motion and stable ligaments. A Functional Abilities Form completed on the same date notes no functional limitations.

[9] The worker attends chiropractor, Dr. B. on January 6, 2010. The chiropractor completes a Doctor's Progress report and Functional Abilities Form noting there is a possible change in the diagnosis as he is unsure what the initial diagnosis was. The worker presents with sub-acute right sacro-iliac joint dysfunction with associated muscle tightness. The worker's subjective

complaints include: “feels twisted in pelvis; cannot bear too much weight on right side; right knee feels similar to meniscal injury a few years back.” Dr. B.’s objective findings note “motion restriction in right sacro-iliac joint; hyperflexion tight right gluteus medius and right quadratus lumborum/right medial compression test provocative; second right popliteus tightness.” Dr. B. estimates the worker’s functional limitations as one week. He is fit for modified duties with no heavy lifting or extended standing or sitting. The worker is having difficulty with weight bearing on the right sacro-iliac joint.

[10] Dr. A.’s January 7, 2010 progress report states the worker has “pain distal to right medial joint line”. Dr. A. recommends the worker “likely needs MRI +/- ortho for reassessment” and advises the worker not to lift patients as his knee hyperextends. The Functional Abilities Form states the worker has functional limitations with walking and problems with the right knee hyperextending. He has pain with carrying heavy clients with the potential of having the knee give out. Dr. A. sets the duration of functional limitations as one month.

[11] A January 7, 2010 note to file by the adjudicator states the worker called to say he would be taking tomorrow off due to his back and his knee may have a possible tear. He attended his family doctor on November 19th and is attending the chiropractor. The worker explained that because he is a paramedic, he has been icing his knee and back. He is doing dispatch at work but lately his pain has been getting worse. “Tomorrow” he will attend another chiropractic appointment and will not be working.

[12] On January 19, 2010 the adjudicator writes to the worker explaining her reasons for not accepting his claim for compensation. She sets out section 4 and 14 of the 2008 *Act* and notes the worker has a previous claim for a right knee injury which occurred on July 13, 2008 with resultant surgery on October 24, 2008. The adjudicator further notes the worker suffered a “serious” knee condition as a result of personal athletic activities in 2002 which also resulted in June 2, 2005 surgery.

The adjudicator states the worker did not seek medical attention for the October 21, 2009 injury until November 19, 2009. There was no objective medical evidence to support a diagnosis of knee sprain. She finds it “unlikely” that the recent time loss and medical treatment the worker has incurred is linked to the October 21, 2009 incident.

[13] Dr. A.’s states in his June 9, 2010 letter that he is writing to clarify what type of injuries the worker suffered on October 21, 2009. Dr. A. notes that prior to that injury, the worker had no pain in his right knee since recovering from right knee arthroscopy in July of 2006. Dr. A. states:

He was functioning independently as a paramedic, and I had observed him pulling a stair chair up and down stairs in the ambulance station loaded with a simulated patient, without difficulty. This test was done specifically to determine if he could function in this capacity prior to going back to work in an unrestricted fashion post-op. It is my opinion that his October 21, 2009 injury likely caused the pain he has described in his right knee and his low back since.

[14] The hearing officer renders a decision on July 7, 2010, confirming the adjudicator's January 19, 2010 decision and denying the worker's appeal.

[15] An MRI Arthrogram of the right knee completed on January 24, 2011 states:

Comment: Medial compartment chondromalacia with full thickness cartilage clefts. Attenuated medial meniscus consistent with the given history of previous partial meniscectomy. Small medial meniscal free edge tear.

[Note: Chondromalacia - What is chondromalacia? Chondromalacia is due to an irritation of the undersurface of the kneecap. The undersurface of the kneecap, or patella, is covered with a layer of smooth cartilage. This cartilage normally glides effortlessly across the knee during bending of the joint. However, in some individuals, the kneecap tends to rub against one side of the knee joint, and the cartilage surface become irritated, and knee pain is the result.

What happens to the cartilage with chondromalacia?

Chondromalacia is due to changes of the deepest layers of cartilage, causing blistering of the surface cartilage. The pattern of cartilage damage seen with chondromalacia is distinct from the degeneration seen in arthritis, and the damage from chondromalacia is thought to be capable of repair, unlike that seen with arthritis. – *Johathan Cluett, M.D., About.com Guide*]

[16] An April 8, 2011 Initial Assessment Report by a physiotherapist provides a summary of both the July 13, 2008 and October 21, 2009 injuries and the worker's reporting of it. Excerpts include:

Currently, [the worker] reports that he has immediate pain with any walking, up or down stairs and he is unable to run. On assessment he is unable to fully extend his leg and he has pain with overpressure and the knee is still not fully straight. He is also tender to palpate along the medial joint line. This (sic) signs are consistent with a significant meniscus injury. After reviewing the records [the worker] did not have these symptoms when he was discharged from treatment on April 9, 2009 as he was fully able to extend his knee. The symptoms [the worker] has reported since the accident on Oct 21, 2009 are consistent with a new injury to the meniscus.

The physiotherapist notes the worker is an avid cyclist and reports no pain while cycling. The physiotherapist states this is consistent with some types of meniscus injuries. Cycling is frequently used in the rehabilitation of knee injuries both post-operatively and to strengthen knees that are injured but have not undergone surgery.

[17] A May 2, 2011 letter to the worker from the adjudicator denies his request to reopen his claim. She states she has reviewed the physiotherapist's report and discussed it with him. She notes the report does not contain objective medical evidence which would cause her to change the January 19 or March 22, 2010 adjudicative decisions or the July 7, 2010 hearing officer's decision.

[18] Dr. C., orthopaedic surgeon, reports on June 1, 2011. Following are excerpts from his report:

Impression: This man has had what sounds like 2 arthroscopic medial meniscectomies and probably is missing most of his meniscus by now. He is developing medial compartment osteoarthritis.

I do not think further surgery would be indicated especially as one would be tempted to take out more meniscus which would be bad for him I think.

I have given him advice as far as guarding his activities and staying away from repetitive weightbearing activities and concentrating on things such as bicycling, ice skating, etc.

Claim 3000-2917

[19] The worker had a previous claim (Claim No. 3000-2917) with the board. On July 13, 2008, he was employed as a paramedic. While lifting a stretcher with a patient and equipment onto an emergency vehicle, the worker suffered an injury to his right knee. In discussions with the adjudicator, the worker indicated he had previous knee problems and underwent an arthroscopy.

[20] The adjudicator obtained previous medical records. Following are excerpts from medical reports prior to the July 13, 2008 injury.

- a. Doctor's chart notes dated January 24, 1996 state, "Right knee: Jumped into truck, felt acute right knee medial pain. Worsening pain since then over next 2-3 days. Now settling a bit but remains fussy with medial patellar pain. No previous knee problem."
- b. January 24, 1996 Radiology Report of the right knee with patellar view states, "No significant abnormality."
- c. Doctor's chart notes dated April 17, 2001 state, "After a hard long run 4 weeks ago (1 ½ hour run) 24 hours later right and left knee pain. Right knee → medial pain. Left knee → lateral patellar pain. Pivoting hurts right knee. Stairs hurt left. No swelling. No remote history."
- d. A May 24, 2002 Radiology Report of the right knee states, "No abnormality seen." Chart notes of the same date state, "Follow-up right knee. MJL (medial joint line) pain persists. On examination – no effusion, + tender MJL. Ortho. scope."
- e. The worker attends an orthopaedist on June 25, 2002. The orthopaedist reports in part:

On examination his right knee is in a few degrees of varus. He has full range of motion. He has mild medial joint line tenderness. McMurray test is negative. The ligaments are stable. X-ray is normal. His left knee has mild patellofemoral crepitus.

[The worker] has right knee pain which could be a degenerative medial meniscal tear but he has absolutely no mechanical symptoms. His left knee does have some degree of chondromalacia of the patella.

- f. An October 17, 2002 MRI of the right knee shows a "normal study". The menisci, cruciate ligaments, collateral ligaments and extensor mechanisms are normal. Clinical information notes, "Exclude medial meniscus tear or early osteo-arthritis."
- g. November 29, 2002 chart notes reveal the worker continued to get medial pain whenever he had a twisting motion to his right knee. Although the doctor does not know the source of the pain, he advises the worker not to undergo arthroscopy at that time.
- h. An October 24, 2004 MRI of both knees reveals a "radial parrot-beak tear along the inner margin of the posterior horn the medial meniscus" of the left knee. The right knee shows no abnormalities except for a small cyst within the central tibia.
- i. January 25, 2005 chart notes state the worker attended for follow-up to his knees. Chart notes state the left knee is pretty good. The right knee remains very sore and fragile. On examination there is a full range of motion. Options discussed were an orthopaedic consultation and "scope both [knees]".
- j. On June 2, 2005 the worker undergoes a "right knee scope, partial medial meniscectomy, and left knee scope, debridement of medial femoral condyle" surgical procedure. The post-operative diagnosis is "Right medial meniscal tear and left knee chondromalacia."

Post July 13, 2008 documents - Claim No. 3000-2917

- [21] The worker attends the Emergency Department of Whitehorse General Hospital on the day of the injury. Dr. D., general practitioner, notes the worker's description of injury as pain at the right mid-knee when planting foot and lifting stretcher. Dr. D. notes the worker had arthroscopy 8 years ago. The diagnosis is a soft tissue sprain.
- [22] The worker's family doctor, Dr. A., reports on July 18, 2008 that the worker is unable to lift and puts him off work from July 23 to July 25, 2008. A previous prescription note of July 14, 2008 by a walk-in clinic doctor puts the worker off work for medical reasons for July 14, 15, and 16.
- [23] A Doctor's Progress Report and Functional Abilities Form dated August 12, 2008 by Dr. A. states the worker has improved range of motion with walking straight but has ongoing pain with twisting/jarring of the right knee. The treatment plan is for the worker to continue with Naprosyn and "try swimming for range of motion knee." Dr. A. notes the worker is fit for light duties only and advises no lifting of patients. The worker is booked for an MRI. Dr. A. notes "If WCB wants to expedite, please do so by all means."
- [24] Dr. A.'s August 21, 2008 Progress Report and Functional Abilities Form states the worker continues to improve slowly but still has pain over the medial right knee distal to the joint line. He is to try going back to work on dispatch only, with no lifting of patients.

- [25] The adjudicator informs the worker via letter dated August 22, 2008 that she is accepting his claim for compensation for the July 13, 2008 work-related injury. She notes the worker has a "pre-existing non work-related injury of the knee requiring an arthroscopy."
- [26] A September 25, 2008 MRI of the right knee states, "Impression: 1. Complex medial meniscal tear; 2. Chondral abnormality involving the medial femoral condyle and superolateral patella."
- [27] The worker attends Dr. E., orthopaedic surgeon, on September 26, 2008 for a consultation. Following are excerpts from his report:
- Impression: Degenerative medial meniscus tear right knee.
- Plan: I think the main cause of his pain is his new medial meniscus tear. Given the absence of obvious arthrosis on the x-rays, I think it is not unreasonable to offer him an arthroscopy given the fact that his symptoms have not improved over the last two or three months.
- [28] The worker undergoes right knee arthroscopic partial medial meniscectomy surgery on October 24, 2008 by orthopaedic surgeon, Dr. E. The post-operative diagnosis is "degenerative medial meniscus tear, right knee, plus early medial osteoarthritis."
- [29] The worker begins physiotherapy on November 10, 2008. Subjective findings indicate the worker initially had a large amount of swelling. It has subsided and now he only has swelling at the end of the day. The physiotherapist recommends the worker undergo treatment 3 times a week to increase his range of motion and decrease pain levels. Treatment will consist of using the pool and stationary bike beforehand.
- [30] On November 20, 2008 the worker attends Dr. E. for a follow-up consultation. Dr. E. reports in part:
- [The worker] has some mild medial joint line pain, but it is not as bad as it was before. I noted that during the arthroscopy, we confirmed a very macerated complex horizontal cleavage tear of the medial meniscus, in which there was a fair bit of horn. He also has some mild chondromalacia of the medial compartment. This gentleman is at risk of developing medial compartment osteoarthritis. I have told him that at this juncture he requires more time with physiotherapy to work on pain relieving methods so that we can allow the knee to heal. I would anticipate that he will likely take the full six to eight weeks of rehabilitation.
- [31] Dr. A.'s Progress Report and Functional Abilities Form dated November 21, 2008 states the worker continues to improve with increasing range of motion. The treatment is an articulated brace and deep massage to increase mobility. The worker is fit for modified duties as a dispatcher only effective November 22, 2008.

- [32] Dr. A.'s Progress Report and Functional Abilities Form dated February 17, 2009 reveals a change in diagnosis. The worker attends with increased pain and swelling and is unable to fully extend his knee. There is pain with "anterior medial meniscal pressure." The worker has functional limitations with walking and is unable/unsafe to lift patients.
- [33] The physiotherapist reports on February 27, 2009 that the worker is becoming increasingly more frustrated with the lack of improvement in his knee since the surgery. His knee swells with activity and he is unable to extend his leg. Dr. A. prescribed a NSAID (non-steroidal anti-inflammatory drug). The worker reported an immediate improvement in symptoms. Frequency of treatment is decreased to once per week. The physiotherapist notes the worker should be able to return to full duties after his next appointment with the surgeon if the swelling does not increase when he increases his strengthening exercises. He will need to wear his brace when he returns to work.
- [34] Dr. A. reports on April 1, 2009, "Impression: Synovial sac polyp lesion. Leg improving with pain/mobility. Consider reassessment with surgery. MRI more likely useful."
- [35] Dr. A.'s April 20, 2009 Progress Report notes the worker's knee continues to improve. The worker is fit for full duties; he has no functional limitations and is fit for a trial of back to work.
- [36] On August 6, 2009 a board case manager writes to the worker informing him that his claim for compensation has been closed.
- [37] The worker submits a new Report of Injury/Illness for a new incident – Claim No. 3000-5263. Dr. A. recommends another MRI of the knee. On February 12, 2010 an adjudicator asks the board medical consultant to review both claim files and provide an opinion as the worker has requested a reopening of his compensation claim(s).
- [38] The medical consultant reports on March 10, 2010. She opines that the worker's present symptoms are not a direct cause of the 2008 injury and/or subsequent operation and notes the worker has had chronic right knee pain since 2002. The worker underwent bilateral arthroscopic knee surgery on June 2, 2005. Post-operative findings indicated "right medial meniscal tear and left knee chondromalacia." The medical consultant states that the findings indicated there was evidence of degenerative changes in the knee as far back as 2005.
- The medical consultant notes "his symptoms are clearly related to his primary injury of 1996 which continued through 2002 and 2005. It will be my suggestion that the MRI being requested at this time should not be the responsibility of the WCB." In her opinion, although the worker suffered a minor injury at work in 2008, the subsequent meniscal tear resulted from the original injury in 1996 which caused degenerative changes in the medical meniscus found in 2008.
- [39] A March 22, 2010 letter to the worker from the adjudicator denies the worker's request to reopen his claim. She states that although the worker indicated he had pain in the same area as his 2006 injury, "neither your employment, nor the action of slipping backwards and catching your foot has caused your present symptoms." The adjudicator states the medical evidence has linked the worker's right knee pain to his pre-existing non work-related condition.

The Worker's Testimony

[40] The worker explained the October 21, 2009 injury to his knee.

He and his partner were called to move a semi-conscious critical patient who required urgent attention. The patient was a man who weighed approximately 280+ lbs. They needed to use a stair chair, which weighed in excess of 30 lbs. As they entered the building, he noticed a woman mopping the stairwell. The stairs were wet. The patient they had to remove was located in a basement suite in the building.

The worker was at the top of the stairs and needed to bend down to lift the patient up in the stair chair. As he and his partner were pulling the patient up on the stair chair, his foot slipped underneath and the entire weight of the patient and stair chair crashed down on his right knee. He experienced a sharp pain immediately and his knee hyperextended. This also caused pain in his right lower back. Because the patient was in critical condition, he and his partner finished the lift, put the patient in the ambulance and took him to the hospital.

[41] The worker said he tried treating himself at the ambulance station by applying ice to his knee and back for 10 minutes, taking it off for 10 minutes and then reapplying for 10 minutes for the first 48 hours. He elevated his knee. After the 48 hours he used ice and heat consecutively and was taking the maximum amount of Ibuprofen. Instead of driving the ambulance and doing his usual duties, he took dispatch duties in order to rest his knee. The worker said as time went on the pain developed into a deep throbbing pain and he could not continue to work so he took 4 days off work. To date, he cannot do certain things such as run, lift heavy objects or twist his knee in any way.

[42] The worker provided a history of issues he had with his knees previously.

1. He said many years ago while working as a firefighter in another city, he had both of his knees "scoped". The surgeon told him that a minute piece was removed from his knee. This was not a compensation claim. After they completed the procedure he was able to walk out. He missed a few days of work and needed to go through a rigorous firefighter physical to ensure he was 100% capable of doing the job. This entailed running up 7 flights of stairs carrying a 75 lb. roll of hose, completing a "dummy drag" up the stairs and on the tarmac, lifting heavy ladders on and off the trucks, and stepping up onto the bumper of the truck while lifting hoses. This was done with a firefighter training officer, the captain and a medical doctor present.
2. His second injury was in Whitehorse and was a compensation claim. He was lifting a heavy patient on a stretcher and took a big step when he heard a snap in his knee. He said in addition to the weight of the patient, there were hundreds of pounds of equipment on the stretcher. After his surgery for this, he had to spend an extra night in Vancouver for recovery and had to be discharged in a wheelchair (rather than walking out). His treatment plan consisted of wearing a brace and attending physiotherapy in addition to doing stretching, exercises, riding a stationary bike and taking medication. He had to use a cane for a long time afterwards.

3. This last injury to his knee occurred in Whitehorse. He felt a sharp pain in his knee after the stair chair crashed onto it. The worker said he did the same physiotherapy on himself as they did at the centre: stretching and riding the stationary bike in addition to icing and heat on his knee. He also used the whirlpool/hot tub.

- [43] The worker testified that he delayed going to the doctor from October 21st, the day of injury, until November 19, when he attended the doctor, was because he thought his knee was going to get better. He was working at light duties and he could not get an appointment with the doctor right away. His normal work routine was two 10-hour day shifts; two 14 hour night shifts and then 4 days off. Eventually his back got better but his knee continued to bother him.
- [44] He said the doctor originally told him he had a knee sprain and if there was a tear, it was minimal. The MRI results revealed a significant tear. The worker said that the most recent injury also resulted in a significant tear to his knee. The second MRI confirmed this.
- [45] The worker said that any and all exercise he undertakes has been approved by the physiotherapist, his doctor and both surgeons/specialists. Cycling and swimming are the only activities that have no impact on the knee. Immediately after surgery, he used the exercise bike in order to get as much flexion as possible, to increase blood circulation and to help build muscles in the knee. If he does not exercise, his knee becomes worse. It does however hurt to walk.
- [46] He said he has been very active all of his life. After the October incident, he could barely move for the first week because his back was sore and he had pain in his knee. He needed to get moving after that so he participated in swimming and cycling, completed stretching exercises and also did some "light weights".
- [47] The worker said he spoke to a visiting joint specialist who told him the previous surgeries have removed so much that the knee cannot be repaired. The other option is to have a false knee put in. The worker does not want a fake knee and would like a second opinion from a sports specialist/surgeon. His hope is to be able to walk without pain. Presently, he has a loader brace which takes the weight off his knee but does not exercise the muscle, causing it to weaken. He only wears it if he tries to walk any distance or goes for a short hike.
- [48] The worker testified the injuries have significantly impacted his career. He can no longer lift patients, he cannot weight bear on his knee and he cannot twist it. He had to change his career from a job that he loved to one which is very stressful. If not for the last injury, he said he would still be working as a paramedic, working in the field and treating patients. He was going to train as an advanced paramedic and wanted to be a flight medic. He is now employed as a 911 dispatcher. He cannot go back to his previous job as he may re-injure his knee.

The Workers' Advocate's Submission

[49] The advocate referenced the following policies:

- EN-01, Arising Out of and In the Course of Employment
- EN-07, Pre-existing Conditions

She provided excerpts from Terence G. Ison's, *Workers' Compensation in Canada*, 2nd ed.

[50] She says the Worker's and Employer's Reports of Injury/Illness confirm there was an incident on October 21, 2009 involving a stair chair. The worker provided testimony how the injury occurred and how his symptoms progressed over time. This information supports there was an injury which happened at work and while the worker was conducting a work-related task. The advocate submits this meets the criteria contained in Policy EN-01, Arising Out of and In the Course of Employment.

[51] The advocate says the worker reported the injury as required by the *Workers' Compensation Act* on October 21, 2009. As his symptoms progressed he continued to treat the injury as he initially did and sought medical treatment in an effort to recover from the injuries. She submits the worker has fulfilled his requirements under the *Act*.

[52] A decision letter dated March 22, 2010 by an adjudicator concludes there is no evidence establishing a direct link between the worker's current right knee pain to the work-related injury of 2008. She further notes the present medical evidence indicates right knee pain from a pre-existing non work-related condition. The advocate contends the worker's previous injury had healed to the point where he was fully functioning as a paramedic. This is supported by Dr. A.'s April 20, 2009 Progress Report and a June 9, 2010 letter. The letter confirmed Dr. A.'s attendance at the ambulance station to observe the worker completing simulated duties to determine his functional abilities in this previous heavy work category after right knee arthroscopy in July of 2008. The worker was deemed fit to resume work in his previous capacity as a paramedic. The advocate submits the worker made a full recovery from the 2008 injury. Notwithstanding the evidence that the worker had made a full recovery, both the adjudicator and hearing officer raise the worker's previous knee injuries as a concern.

[53] The advocate says at this point, and largely due to the full recovery of the worker, the claim should have been accepted as a subsequent injury under Policy EN-07. When the adjudicator copied the medical reporting from the previous claim and considered a re-opening of that claim, the decision which resulted was that the medical evidence linked the worker's right knee pain to his pre-existing non work-related condition. She says Policy EN-07 directs that if a pre-existing condition has been accelerated as a result of a work-related incident, the board shall provide compensation only for the accelerated portion of the pre-existing condition. Also, if the pre-existing condition is degenerative in nature, the board is responsible to return the worker to the point he/she would have been if not for the work-related incident. The "thin skull" rule suggests that you must take your victims as you find them which means that a worker's injuries are compensable even if they are unexpectedly severe for that individual, owing to a pre-existing condition.

- [54] The advocate maintains this worker's pre-incident state was that he was fit to work with no restrictions in his position as a primary care paramedic, considered a heavy strength occupation. Regardless of whether the injury is determined to be a recurrence of a pre-existing condition, either compensable or non-compensable, or if it is a new injury, she submits, the board is responsible for providing the worker with compensation benefits he is entitled to under the legislation. She says he was legitimately injured at work.
- [55] The advocate notes the adjudicator referenced section 14(1) of the *Act* which states that workers must take all reasonable steps to reduce or eliminate any impairment and loss of earnings from a work-related injury. She notes the worker is a paramedic. He did take every reasonable step to mitigate his injury, including promptly reporting the injury as required. The worker testified that in an effort to manage his own health and well-being, he regularly applied ice to his back and right knee and he requested and assumed lighter duties in the form of dispatcher. These changes allowed him to remain working in his own occupation as a paramedic with minimal time loss. Due to the latest injury, he has taken a permanent position of dispatcher due to his physical limitations; a job that he is not particularly passionate about.
- [56] The adjudicator noted that since the worker was a paramedic and suffered two serious knee conditions previously, it would be reasonable for him to have sought medical attention immediately. The advocate submits that once the worker realized his injuries could be more significant than he first thought, he made an appointment with his family doctor. She says it is not uncommon to wait for an appointment with a family doctor in the Yukon.
- [57] The advocate says the question that must be asked is: Did the accident at work on October 21, 2009 have anything to do with this worker's ongoing pain symptoms and physical limitations?
- [58] She says the board accepted responsibility for the worker's previous knee injury including subsequent surgery and physical conditioning/rehabilitation in 2008. She contends the circumstances of both injuries are very similar in nature and progression. Although the worker experienced past injuries to his knee and may have suffered a recurrence, the injuries were advanced in time and certainty because of the October 21, 2009 workplace accident.
- [59] The advocate maintains the worker went to work on October 21, 2009 as a fully functioning paramedic. He suffered an incident while moving a patient in the stair chair. As a result, his physical condition has not been the same.

Relief Requested

The worker asks the appeal committee to reverse the hearing officer's July 7, 2010 decision and that his claim be accepted either as a new injury or as an aggravation of a pre-existing condition. He asks that he be provided with wage loss, medical benefits and interest as a result of the injury.

Issue: Did the worker suffer a work-related injury or an aggravation of a pre-existing condition?

Issue: Is he entitled to compensation as a result of the October 21, 2009 incident?

Answer: The worker suffered a work-related injury on October 21, 2009. He is entitled to compensation.

Reasons and Findings

- [60] The tribunal has to decide whether the worker's right knee condition was due to degenerative changes or to a specific work place incident on October 21, 2009 which caused damage to his knee. Both possibilities have been presented as reasons for the worker's knee problems.
- [61] File documents indicate the worker had previous knee problems dating back to 1996. The worker reported he jumped into a truck and felt acute right knee medial pain. That settled soon after and he was able to continue his work as a firefighter. Again in 2002, after an hour and a half run, he experienced knee pain along the medial joint line. A November 2002 MRI did not reveal any abnormalities and the worker was advised to treat it symptomatically with ice and anti-inflammatory medication.
- [62] The medial joint pain persisted and by August 2004 was reported as "intense medial joint line pain". An MRI taken in October 2004 shows a normal examination to the right knee; the left knee has a small tear along the posterior horn of the medial meniscus. On February 10, 2005 a doctor's report from Pan Am Sports/Surgical Centre states: "We did review the MRI again ourselves and could not find any significant abnormality on the right side. However, the nature of the symptoms do suggest possible medial meniscus tear on that side." The post-operative report dated June 2, 2005 confirms there was a right medial meniscus tear.
- [63] We note the worker experienced symptoms of a possible medial meniscus tear which did not show up on an MRI but became clear during surgery on the knee. It is therefore evident to us the worker knows what the pain of a meniscus tear feels like.
- [64] Again, when experiencing similar symptoms after a work-related incident to the knee, a 2008 MRI confirmed a complex medial meniscus tear in the worker's right knee. Dr. E., the orthopaedic surgeon, who performed surgery on the worker's knee, did a follow-up examination in November 2008 and commented, "I did mention in passing that given the arthroscopic findings, if persistent medial sided pain is related to activity, he may be a candidate for an unloader brace."
- [65] The board hearing officer, when analyzing Dr. E.'s reporting, suggested that it was quite likely, given the arthroscopic findings, that the worker might experience persistent medial sided pain with activity in the future. The hearing officer states, "This medial sided pain with pressure that did occur (after the incident) was, in fact, pain with activity in the future." He then concluded that the pain the worker was experiencing was a natural progression of the degenerative nature of his right knee. He found there was a pre-existing condition which negated the work-related component of the worker's injury.

- [66] The committee points out the worker was involved in many paramedic activities prior to the October 2009 incident and did not suffer any medial sided pain. He experienced pain instantly when the stair chair hit his leg.
- [67] The medical consultant linked the worker's knee problems to the injury in 1996 which continued through 2002 and 2005. She opined that the meniscal tear was subsequent to the minor work injury suffered by the worker in 2008 also as a result of the 1996 injury. This caused the degenerative changes in the medial meniscus found in 2008.
- [68] The medical consultant notes "his symptoms are clearly related to his primary injury of 1996 which continued through 2002 and 2005. It will be my suggestion that the MRI being requested at this time should not be the responsibility of the WCB." In her opinion, although the worker suffered a minor injury at work in 2008, the subsequent meniscal tear resulted from the original injury in 1996 which caused degenerative changes in the medial meniscus found in 2008.
- [69] Since the worker did not seek immediate medical aid, the board did not consider the stair chair incident to be serious enough to warrant further investigation or to be compensable.
- [70] The requirement of the *Act* is that the injury has to be work-related which is clarified by Policy EN-01, Arising Out of and In the Course of Employment.

Policy EN-01 requires that the disability be work-related. It has to arise out of employment and in the course of employment. Following are excerpts from Policy EN-01:

General

Entitlement for compensation will be awarded when an injury arises out of and in the course of employment. This means that an injury results from the nature, condition(s) or obligation(s) of the employment and that the injury happens at a time, place and circumstances consistent with the employment.

1. Arising Out of Employment: means that an injury is linked to a worker's employment in terms of time, place and activity consistent with the obligations and expectations of that employment.
2. Arising in the Course of Employment: means that an injury is linked to a worker's employment in terms of time, place and activity consistent with the obligations and expectations of that employment.

- [71] On August 6th the worker was cleared to go back to work without restrictions. He was able to meet the requirements of his job description, which included some heavy physical demands. He performed his job without problems until October 21, 2009 when he suffered the stair chair incident. He has been unable to fulfill the requirements of a paramedic job since that time and is now employed as a 911 dispatcher.

- [72] Did the incident arise out of employment? The worker, a paramedic, hurt his knee (and back) which disabled him from performing any of the more physically demanding duties of his job. This disability arose out of his employment as a paramedic; the activity he was involved in was a requirement of his job.
- [73] Did the disability arise in the course of employment? The worker was on his assigned shift doing an assigned task in the same manner he had done it many times before. While at work, his foot slipped on a wet stair causing the full weight of the stair chair to impact his right leg, injuring his right knee.
- [74] The committee finds that the worker's disability arose both out of his employment and in the course of his employment.
- [75] The committee questions the board's attempt to link the October 2009 injury to the worker's previous claim 3000-2917. It is clear the worker received an injury at work on October 21, 2009. He testified he felt a sharp pain in his knee immediately after the stair chair crashed onto it. He completed and submitted the required report of injury; however, the adjudicator does not find his injury is work-related and states, "I believe that there was an incident where you slipped backwards while assisting a patient in a stair chair but I found no evidence of a work-related injury . . . neither your employment, nor the action of slipping backwards and catching your foot has caused your present symptoms."
- [76] We point out that both the hearing officer's and the adjudicator's findings centre around the following:
- 1) The worker's previous knee problems have led to a severe degenerative condition in his knees which will cause him pain in the future as pointed out by Dr. E., the orthopaedic surgeon.
 - 2) The fact that the worker did not take any time off because of the incident. They found the incident was of a very minor nature and did not fall within the definition of a work-related injury.
 - 3) The time frame between the incident and the worker's first visit to the doctor. It appears both the adjudicator and hearing officer denied the claim because of the length of time that passed before he attended the doctor, ruling out a serious injury.
- [77] The *Act* provides for compensation for work-related injuries to workers. Policy EN-07, Pre-existing Conditions, recognizes that pre-existing conditions may negate a worker receiving compensation although an incident at work triggered the injury. Policy EN-07 states, in part:
- b) Non-compensable Pre-existing Conditions
The decision-maker may determine that the worker's pre-existing condition is not work-related. The YWCHSB will provide compensation for a worker's non-

compensable pre-existing condition that has been aggravated as a result of a work-related incident. Once the pre-existing condition has returned to its pre-incident state, the YWCHSB is no longer responsible for compensation.

If a pre-existing condition is degenerative in nature, the YWCHSB is responsible to return the worker to the point he or she would have been if not for the work-related incident. The YWCHSB is not responsible for the natural progression of a degenerative pre-existing condition into the future.

c) "Thin Skull" – The Pre-existing Condition Becomes Compensable
The "thin skull" rule is a long-standing principle in tort law that suggests you take your victims as you find them. Applied to workers' compensation, this means that a worker's injuries are compensable even if they are unexpectedly severe for that individual, owing to a pre-existing condition.

Example: A transportation worker is moving a 300 lb. load up a flight of stairs when the load slips, causing fright and strain. The worker has a heart attack. The medical evidence indicates a deteriorating condition of the heart. But it supports a conclusion that the worker could well have survived for months or years without a heart attack had it not been for this unusually strenuous experience. Based on the balance of probabilities, the heart attack would be considered work-related, and therefore compensable.

d) "Crumbling Skull – The Pre-existing Condition is Not Compensable
The "crumbling skull" rule is another long-standing principle in tort law (though less known than the "thin skull" rule). The principle is intended to differentiate cases where 'what you see' is similar to 'what you would have expected' if not for the work-related incident.

Example: The principle would apply to exclude compensation where a worker with a heart condition is climbing the stairs to work and suffers a heart attack. It is only chance or coincidence whether it happened at work, at home or elsewhere. The disability is one that the claimant would not have escaped regardless of the work activity.

[78] We point out that this case differs substantially from the example used in the policy in that the worker was performing a task he would do only at his job and not in his everyday life away from work.

[79] The committee finds the worker complied with the requirement of the *Act* by reporting the work-place incident to his superiors and filing the proper documents with the board. As a paramedic and from his previous visits to doctors in regards to his knee, he was aware of the procedure to treat what he thought to be a knee strain at the time. The knee did not improve and the worker sought medical advice from his own physician who saw him a month after the incident. (We understand it is difficult to get an appointment with a doctor on short notice).

[80] We point out, although it is fact the worker hardly missed any work time because of his injury, he was unable to perform his paramedic duties and took the dispatch position only until his knee and back healed. The board was correct in stating that the worker experienced little or no time loss because of the incident, but they did not refer to the fact that the worker was no longer able to work in his chosen profession because of the incident.

[81] A subsequent MRI in January 2011 showed medial compartment chondromalacia with full thickness cartilage clefts . . . small medial meniscal free edge tear.

Dr. A., in a March 2011 report, states that in his opinion the worker's current knee problems are due to his October 2009 incident at work. He also feels the injury did not cause an acceleration of the degenerative disease in the worker's right knee nor that it can be classified as an aggravation of a pre-existing condition.

In April 2011, Physio Plus reports the worker's symptoms are consistent with a new injury to the meniscus as he did not have any of the symptoms when he was discharged two years earlier.

Dr. C., orthopaedic specialist, reports in June 2011 on the MRI findings and advises the worker to guard his activities and stay away from repetitive weight bearing activities.

[82] We realize that statements made a year and a half after the incident carry little weight; however, they must be taken into consideration, especially from those who have had prior contact with the worker. It is interesting to note that all three reports recommended that bicycling is good for rehabilitation of the knee.

[83] The committee gives more weight to the reports of the treating health care professionals than those made of the non-treating health care professionals.

[84] The committee finds the worker suffered a work-related injury that arose out of and in the course of his employment which kept him from performing his duties as a paramedic.

Conclusion

[85] We conclude that the worker suffered a work-related injury on October 21, 2009 to his right knee. This has kept him from continuing in his chosen paramedic career.

[87] We conclude that various medical professionals have conflicting opinions for the worker's present condition. We give more weight to the findings of those who had personal contact with the worker.

[88] We conclude the worker is entitled to compensation for time loss and all medical expenses incurred as a result of the October 21, 2009 work-related injury.

Decision

The worker's appeal is allowed. The hearing officer's July 7, 2010 decision is reversed.

1. The worker is entitled to loss of earnings benefits in accordance with section 22 of the *Act* and Policy EL-01.
2. The worker is entitled to medical expenses incurred as a result of the work-related injury.
3. The board shall pay interest on compensation in accordance with board Policy EL-03 and section 31 of the *Workers' Compensation Act*, S.Y. 2008.

Dated this 2nd day of **December 2011** in the City of Whitehorse, Yukon Territory.

M. McCullough, Member

H. Leenders, Committee Chair

H. Hermanson, Member