WCAT Decision Number: WCAT-2005-06724
WCAT Decision Date: December 16, 2005
Panel: Joanne Kembel, Vice Chair

Introduction

The employer has appealed a March 18, 2005 Workers' Compensation Board (Board) Review Division decision confirming an earlier Board decision to accept the worker's claim for right thumb complaints.

The employer asked that this matter be determined on the basis of written submissions and a review of the claim file. Both parties prepared submissions. Since this matter involves primarily a question of medical causation as well as the application of law and policy, I am satisfied that an oral hearing is not necessary.

Issue(s)

Was the worker's right thumb/wrist condition due to the nature of her employment?

Jurisdiction

Section 239 of the *Workers Compensation Act* (Act) authorizes an appeal from the Review Division on specific matters to the Workers' Compensation Appeal Tribunal (WCAT). WCAT was established on March 3, 2003 by the *Workers Compensation Amendment Act (No. 2), 2002* (Amendment Act). Section 250(2) of the Amendment Act requires that I apply the policies of the board of directors of the Board, found in the *Rehabilitation Services and Claims Manual, Volume II* (RSCM II).

Background and Evidence

The worker was 40 years old and had been working in the employer's fish packing plant for approximately five months when, on September 16, 2004, she sought first aid attention for pain and swelling in her right hand at the thumb. The first aid attendant completed a report and recorded the worker's symptoms had begun approximately two and one-half months earlier. She had seen her regular physician, Dr. W. Lee, the day before and he had given her a note, on which he indicated the worker should not work for one month. However, the worker wanted to continue working. In light of this, the first aid attendant provided her with a splint/brace and arranged for her to work light duties using her left hand only.

On the employer's report to the Board, the employer indicated the worker's job was a pin boner; she repetitively pulled bones out of fish using tweezers.

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A Board case manager spoke with Dr. Lee on October 4, 2004. Dr. Lee stated he was willing to discuss the matter with the case manager but had not filed a report because he had not been paid for reports in the past. He indicated that although he had seen the worker before, he had not seen her for this current condition until recently. He indicated a diagnosis of gradual onset repetitive strain injury of the worker's right thumb and index finger.

On October 13, 2004, the Board case manager spoke with the worker, who denied any past problems with her right wrist, hand or thumb and denied any current systemic medical conditions. Dr. Lee had not ordered tests but had prescribed anti-inflammatory medication and her pain was diminished somewhat.

On October 22, 2004, the Board case manager reviewed the claim file and recorded a log entry on which he indicated the worker had worked light duties for approximately two weeks before leaving work. She was taking massage therapy and acupuncture in addition to medication. The case manager recorded that he had visited the employer's work site on a number of occasions to view the pin boner job and he accepted that the duties required sustained gripping pressure of the pincers through the thumb, a static pinch grip with thumb and index finger and a static sustained thumb flexion work posture. On a previous claim unrelated to this worker, a Board medical advisor (MA) had reviewed these duties and deemed them causative of right thumb tendonitis.

On November 6, 2004, the worker's acupuncturist reported and reviewed the worker's symptoms. Referring to traditional Chinese medical theory, the acupuncturist indicated the likely diagnosis was tendon strain and arthritis and stated the cold and wet environment in which she had been working may have resulted in this condition.

In a decision letter dated November 8, 2004, the case manager accepted the worker's claim.

The employer requested a review. The employer's representative submitted that there was no clear diagnosis from the worker's family doctor and the extent of arthritis, diagnosed by her acupuncturist, should be assessed.

The worker was assessed at a local activity-related soft tissue disorder (ASTD) program on November 10, 2004. The program occupational therapist issued a discharge report on November 12, 2004. The therapist recorded the history of the onset of the worker's symptoms in her right hand/thumb and recorded that, although acupuncture had helped with swelling, the worker had constant pain along the extensor surface of her wrist, index and thumb areas. She also had pain in both shoulders.

At work, the worker indicated she primarily used her right hand, and occasionally her left hand, to remove bones from salmon, using tweezers. She wore gloves and worked in a refrigerated, typically wet, environment. She had worked approximately 30 hours per

week April through June and increased this to up to 16 hours per day, 7 days per week, over the busy season July through September. The therapist recorded clinical examination findings. The worker had pain on palpation in her wrist, hand, thumb and upper trapezius. She had similar pain on the left, but to a lesser degree. The occupational therapist assessed the worker's job duties. Many of these were bilateral, including lifting, carrying, pushing/pulling and reaching/handling. The occupational therapist indicated the worker would eventually benefit from an ASTD program. However, since she had been wearing a splint, which may have hindered her rehabilitation, and since she had only passive treatment, she should first spend 4 weeks in physiotherapy.

The worker was assessed in November 29, 2004 at a Hand Therapy Centre and her history and examination findings were recorded. On January 5, 2005, an occupational therapist from a different rehabilitation centre completed an ASTD assessment report. This therapist also recorded the work duties as well as the onset of the worker's symptoms. The physician for that rehabilitation centre examined the worker and reported on January 25, 2005.

The physician, an orthopaedic consultant, reviewed the worker's history including her information that her symptoms began in June when she began working 15 to 16 hours per day and that removing the bones from the fish required some significant force. When she stopped working, her symptoms improved, although she had also had acupuncture at the same time and was therefore not exactly clear which factor had benefited her the most. By January 2005, the worker's swelling was gone and the pain level had decreased moderately. The physicians also recorded clinical examination findings as follows:

> At this time, there were really very few physical signs. The most notable sign was the absence of full extension at the interphalangeal joint of the right thumb. This had a hard end-feel even on a passive basis, and the range certainly was less than the active extension available in the left thumb…She reported that this movement loss was new and that her thumb had never been like this before…There was no problem with the left thumb…the range of movement actively available now was within normal limits, although she described early morning stiffness in this area.

The orthopaedic physician concluded the worker had a degree of tendinitis in the right thumb with some potential for a synovial reaction in the interphalangeal joint of the right thumb. He attributed her hand pain to the cold, wet environment in which she had normally worked.

The Board review officer issued a decision on March 18, 2005 and confirmed the Board's November 8, 2004 decision to accept the worker's application for compensation for right thumb complaints. The review officer found the worker's condition was caused by her employment duties. On March 23, 2005, the employer appealed and argued

there was a lack of medical evidence in this matter. With respect to the Board review officer's comments that there was no medical information to support the diagnosis of arthritis, the employer submitted, "This is the point!"

On March 24, 2005, Dr. Lee contacted a Board MA and stated he felt the worker could not return to her previous job due to her persistent thumb tendinitis.

A Board MA referred the worker to the Board's Visiting Specialists Clinic on April 4, 2005. In her referral letter, the MA indicated the worker's most likely diagnosis was a de Quervain's tenosynovitis and asked a hand specialist for an opinion to clarify the diagnosis.

The worker attended the Board's Visiting Specialists Clinic on April 29, 2005, where she saw orthopaedic surgeon Dr. T. Gropper, who ordered a bone scan and x-rays.

On June 24, 2005, Dr. Gropper wrote that, having reviewed the results of the x-ray and bone scan examination, and based upon her initial assessment on April 29, 2005, he believed her continued pain syndrome was not related to a localized abnormality related to the wrist or hand. He thought it likely represented a problem of an ASTD.

The worker saw Dr. Gropper again on August 26, 2005. Dr. Gropper recorded the worker's report of her symptoms. Her right hand pain was diffuse and involved her thumb at various areas but the worker reported the other joints within her hand were better. On examination, there was no significant change from the last time he had examined her. He concluded, "Although this suggests a possible arthritic component, I do not believe that this does represent inflammatory arthritis. This would need to be assessed by a Rheumatologist."

Submissions

In its first submission dated May 16, 2005, the employer submitted the medical information was limited and referred to two medical reports, one which referred to thumb tendinitis and the other which referred to a likely thumb strain and arthritis. The other physician's information had contained no diagnosis and the occupational therapist was not a doctor.

With respect to the Board officer's reliance on a previous claim for tendinitis from another pin boner at the same employer, the employer indicated this would be "well and good" if the medical diagnosis on this claim was clear. The employer argued there was a lack of evidence to support any clear diagnosis on this claim.
The employer referred to "the discharge report" which recorded the worker had ongoing pain in both of her hands and wrists several weeks after she stopped work. The employer questioned how the condition could become worse and expand from her right thumb to her hands and wrists ten weeks after she had stopped working. The employer submitted there was no diagnosis to which her work might be related.

The worker replied on May 23, 2005 and indicated she was feeling better after joining a recovering program. However, when she went back to work, she felt pain.

Following an updated disclosure, the employer addressed Dr. Gropper's August 26, 2005 report and submitted that he had concluded there was a possible arthritic component which would have to be assessed by a rheumatologist. The employer requested this matter be referred back to the Board for further investigation regarding arthritis. The employer addressed other issues, including medical treatment in China and the acceptance of a chronic pain condition.

Although invited to do so, the worker provided no further submission after receiving the updated disclosure.

Findings and Reasons

The worker's injury occurred after June 30, 2002, the transition date for relevant changes to the Act. Entitlement under this claim is adjudicated under the provisions of the Act as amended by Bill 49, the *Workers Compensation Amendment Act, 2002.* Pursuant to the *Workers Compensation Amendment Act (No. 2), 2002* (Bill 63), WCAT panels must apply published policies of the Board. The policies relevant to this appeal are set out in the RSCM II.

Section 5(1) of the Act requires the Board to pay compensation to a worker who is injured arising out of and in the course of employment.

Section 6(1) of the Act provides that where a worker suffers from an occupational disease and is thereby disabled from earning full wages at the work at which the worker was employed, compensation is payable to the worker, as if the disease were a personal injury arising out of and in the course of that employment. Section 6(1) also allows the Board to pay health care benefits where the worker is not disabled from earning full wages.

Section 6(3) of the Act provides that if at or immediately before the date of disablement, the worker was employed in a process or industry mentioned in the second column of the Act Schedule B and the disease contracted is the disease in the first column of the schedule set opposite to the description of the process, the disease is deemed to have been due to the nature of that employment unless the contrary is proved. In the first column of #13 of Schedule B, the conditions include hand-wrist tendinitis, tenosynovitis and shoulder tendinitis.

The RSCM II item #25.10 discusses three legislative requirements for acceptance of an occupational disease. First, the worker must be suffering from a disease designated or recognized by the Board as an occupational disease. Second, the disease suffered by the worker must have been due to the nature of any employment in which she was

employed. Third, as a result of the disease, the worker must be disabled from earning full wages at the work at which she was employed.

In this instance, in keeping with the first requirement of the RSCM II item #25.10, the employer has questioned the proper diagnosis. In particular, the employer has stressed the acupuncturist's reference to arthritis. In this respect, the acupuncturist's diagnosis was consistent with hand specialist Dr. Gropper's reference to a possible element of arthritis to the worker's condition. However, after examining the worker in April 2005, Dr. Gropper felt she likely had an ASTD. After reviewing x-rays and bone scans, Dr. Gropper provided his opinion; although some of her symptoms were suggestive of an arthritic component, Dr. Gropper felt the worker's condition did not represent inflammatory arthritis. Thus, Dr. Gropper's opinion was consistent with the orthopaedic consultant from the hand clinic, who felt the worker had a degree of tendinitis in the right thumb.

I do not read Dr. Gropper's concluding comments with respect to a possible assessment by a rheumatologist in the same way that the employer has interpreted them. I take his concluding comments as an acknowledgement that his expertise is not in the field of rheumatology. Nevertheless, despite his deference to a rheumatologist's expertise, I note that Dr. Gropper offered his own opinion - he felt that the worker's condition was not related to arthritis. Had Dr. Gropper declined to offer an opinion until such time as a rheumatologist had assessed the worker, I may have referred this back to the Board as per the employer's request. However, since he felt comfortable stating an opinion, for the reasons set out below, I accept that in Dr. Gropper's, it was more likely than not that the worker's symptoms resulted from an ASTD.

I am compelled by Dr. Gropper's opinion for several reasons. First, when it became clear that there were different diagnoses for the worker's condition, Dr. Gropper was the expert of choice to whom the Board referred this complicated question. I accept Dr. Gropper as an expert in diagnosis of hand conditions.

Second, Dr. Gropper had the benefit of all of the medical investigations, including the x-rays and bone scans, and provided his opinion on the basis of these, along with his reasons. He explained how the worker's clinical examination findings were consistent with his diagnosis.

Finally, Dr. Gropper had the benefit of having seen the worker's condition over a period of several months. Where the acupuncturist saw the worker immediately, while she might be said to have been in a more "acute" stage of her condition, both Dr. Gropper and the hand clinic orthopaedic specialist commented that many of the worker's more immediate symptoms had resolved. Both Dr. Gropper and the hand consultant felt the worker had an ASTD, with the latter specifying this condition was a degree of tendinitis in the right thumb with some potential for a synovial reaction in the interphalangeal joint of the right thumb.

Based upon Dr. Gropper's opinion, which I see is consistent with the orthopaedic consultant's opinion, I find the worker suffered from an ASTD: tendinitis in her right thumb. I accept that this is a hand-wrist tendinitis condition described in the first column of #13 of Schedule B.

The second column of #13 Schedule B describes in industry or process where there is use of the affected tendon(s) to perform a task or series of tasks that involves any two of the following: frequently repeated motions or muscle contractions that place strain on the affected tendon(s); significant flexion, extension, ulnar or radial deviation of the affected hand or wrist; forceful exertion of the muscles utilized in handling or moving tools or other objects with the affected hand or wrist; and where such activity represents a significant component of the employment.

Although the diagnosis of an ASTD is, by definition, activity-related, Dr. Gropper did not comment as to the specific tasks he felt were causative of the worker's condition. For this, I find I prefer the information recorded by the occupational therapist reports of November 2004 and January 2005, along with the orthopaedic consultant's opinion, who attributed the worker's hand pain to the cold, wet environment in which she had normally worked.

I note that the Board case manager relied upon previous site visits at the employer's workplace regarding a different pin boner. The employer has not taken issue with this. Rather, the employer has submitted this would be "well and fine" if the worker had a similar diagnosis. I accept that, having visited the employer's business on more than one occasion to assess the pin boner position, the case manager had a full understanding of the risk factors associated with the work activities ASTD.

I have established that the worker did suffer from a hand-wrist tendinitis condition. Furthermore, I accept the two occupational therapists' reports as consistent with the case manager's report of the previous site visits. I find the work activities involved sustained gripping pressure of the pincers through the thumb, a static pinch grip with thumb and index finger and a static sustained thumb flexion work posture. I find the pin boning activities involved repetitive, forceful movements with the wrist, thumb and index finger.

The RSCM II item #27.12 addresses the terms used in Schedule B of the Act and provides that the pinch grip is considered to exert more force on the tendons of the thumb and fingers. Thus, I find that the worker's activities exerted force on the tendons in her right thumb. Since the worker was employed in a process or industry mentioned in the second column of the Act Schedule B, and the disease contracted is the disease in the first column of the schedule set opposite to the description of the process, I find the worker is entitled to the presumption that her disease was due to the nature of that employment, unless the contrary is proved.

The concept of the Schedule B presumption is discussed in the RSCM II at item #26.20. The fundamental purpose of Schedule B is to avoid the repeated effort of producing and analyzing medical and other evidence of work-relatedness for a disease where research has caused the Board to conclude that such disease is specific to a particular process or condition of employment. Once included in Schedule B, it is presumed in individual cases that fit the disease and process/industry description that the cause was work-related.

However, item #26.20 also discusses the section 6(3) wording "unless the contrary is proved," which acknowledges the presumption is rebuttable. The Board must consider whether, on the balance of probabilities, there is evidence which refutes the presumption of work-relatedness. If the evidence is more heavily weighted in favour of a conclusion that it was something other than the employment that caused the disease, then the contrary will be considered to have been proved.

With respect to whether the contrary is proved, I have considered the employer's reference to "the discharge report" and the question as to how the worker's condition could become worse and expand from her right thumb to her hands and wrists ten weeks after she had stopped working.

I take the employer's reference is to the November 12, 2004 ASTD discharge report. From this report, I accept the occupational therapist's opinion that the worker had potentially hindered her rehabilitation by wearing a splint on her right wrist. While this may have helped to alleviate the pain she reported she experienced when moving the wrist, the occupational therapist explained that this would have prevented "activation." Furthermore, to say that this report showed the worker's condition had "expanded" is problematic.

This file has been complicated by the attending physician's refusal to file proper medical reports. As a result, there is little objective medical evidence to identify the worker's exact symptoms at the time she began to seek medical attention. In September 2004, the first aid attendant documented pain and swelling in her right hand at the thumb, in two joints, as well as pain in the right elbow and I find this report to be a good starting point. However, without the benefit of a more thorough examination, say from the attending physician or even a physiotherapist or occupational therapist, I am not comfortable concluding that the worker's symptoms expanded or worsened as the employer has submitted.

Furthermore, I note that the occupational consultant who reviewed the worker's case in January 2005 also recorded the worker's description of the onset and development of her symptoms. I accept the worker's statement to the Board that she had previously had no such symptoms in her right hand/wrist. I found her statement to be consistent with the first aid attendant's report; her regular physician Dr. Lee's telephone conversation with the case manager on October 4, 2004; and the November 12, 2004 ASTD discharge report. I find the worker first began to experience symptoms in her

right wrist in June 2004, after having been employed in the pin boner position for approximately two months. She experienced an increase in symptoms which corresponded with an increase in working hours in June 2004. I accept from this same evidence that the worker used her left hand to remove bones from frozen fish when her right hand became fatigued. I observe this was consistent with references to some bilateral symptoms (right worse than left). However, the primary focus was always on the worker's right hand-wrist condition, which was consistently worse than the transitory symptoms in her left hand-wrist. On the balance of probabilities, I find it is more likely than not that the onset and progression of her symptoms was related to her work as a pin boner. I find the references to the worker's left hand and references to changes in her symptoms as of November 2004 or thereafter are not sufficient to rebut the presumption to which the worker is entitled under section 6(3) of the Act.

As an aside, I note that if Dr. Gropper's opinion is wrong and if the worker did develop an arthritic condition in her right thumb, hand and wrist, this would not change my decision that her condition is compensable. I have accepted the worker had no symptoms in her right wrist sufficient to cause her to seek medical attention prior to her employment as a pin boner. Thus, if the worker did have an arthritic condition, it was previously asymptomatic, and, as described in the RSCM II item #26.55, that pre-existing disease would be considered aggravated by work activities to the point where, in September 2004, it became disabling. I say this because the evidence shows that despite any pre-existing asymptomatic condition, the worker was able to commence and maintain the pin boner position for approximately five months. I have accepted that her increase in symptoms corresponded with an increase in work in June 2004. This suggests that, in the absence of the work activities, the pre-existing condition would not otherwise have disabled the worker. Her symptoms reached the point of being disabling while she was working, and more likely than not as a result of the activities associated with the pin boner position. As described in the RSCM II item #26.55, her condition would be accepted as an aggravation of a disease, and compensable under section 6(1) of the Act.

At any rate, I have accepted the worker is entitled to the presumption in section 6(3) of the Act.

Finally, with respect to the employer's submissions regarding other issues such as the worker's entitlement to treatment in China, as well as whether she has a compensable chronic pain condition, I find I have no jurisdiction. These issues were not addressed in the Board review officer's decision, nor were they the subjects of the Board case manager's November 8, 2004 decision.

Conclusion

I deny the employer's appeal and confirm the Board review officer's March 18, 2005 decision. There are no requests before me for reimbursement of expenses, and no

reimbursable expenses within the meaning of section 7 of the *Workers Compensation Act Appeal Regulation, B.C. Reg. 321/02* are apparent to me following my review.

Joanne Kembel
Vice Chair

JK/ml