Noteworthy Decision Summary

Decision: WCAT-2008-02078 **Panel:** David Cox **Decision Date:** July 11, 2008

Section 5(1) of the Workers Compensation Act – Conflicting medical opinions – Credibility

This decision is noteworthy as it provides an example of how to weigh conflicting medical opinions and address credibility issues.

On February 20, 2007 the worker, who was employed as a marine surveyor, twisted his right knee in the course of inspecting a boat motor. The worker attended at the hospital and was diagnosed with cellulitis. A couple of weeks prior to the incident at work the worker, while in Mexico, had skinned his knee when dragging a suitcase out of the trunk of a car and had a small scab on his knee at the time of the work incident.

The Workers' Compensation Board, operating as WorkSafeBC (Board), sought the opinion of a Board medical advisor. In the medical advisor's opinion, four hours for the development of a clinically detectable infection was not biologically plausible. Therefore, there was no reasonable medical causal association to be made between the workplace incident and the worker's need to receive treatment for an infection.

In an April 27, 2007 consultation report, an orthopedic surgeon opined that there was a correlation between the incident and the cellulitis. In particular, the orthopedic surgeon noted that although the worker had an initial scrape outside of work, it was the actual fall and re-injury at work that led to the increased swelling, redness, and obvious infection. In an October 29, 2007 report, an internal medicine specialist provided that the worker had an aggressive bacterial infection that could well have come on rapidly and it was quite possible that it came on over the course of several hours as the worker had claimed.

The review officer at the Board denied the worker's claim on the basis there had been variable descriptions of the mechanism of injury (twist versus fall) and he doubted whether a rapid onset of symptoms could be related to the injury.

The appeal was allowed. The panel found that it was more probable than not that the worker's right knee cellulitis arose out of and in the course of the worker's employment on February 20, 2007. The panel noted that there was no significant discrepancy in the worker's evidence with respect to a mechanism of injury. The discrepancy was in the orthopedic surgeon's interpretation of the worker's history. However, it did not appear that the worker openly provided a differing description of his work activity on February 20, 2007. The panel further found that the worker was capable of a full return to work upon return from his vacation and there was no reliable evidence the pre-existing scrape was a portal site for the subsequent infection. The panel noted that the Board medical advisor's opinion was contrary to those of the treating physicians, most notably to that of the internal medicine specialist, and he preferred the opinion of the internal medicine specialist.

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Introduction

The worker appeals from the December 13, 2007 decision of an officer of the Workers' Compensation Board, operating as WorkSafeBC (Board). That decision of the Board's internal Review Division confirmed an earlier decision of a Board officer dated April 24, 2007 to deny the worker a claim for a right knee cellulitis said to have occurred in the course of his employment on February 20, 2007.

The review officer was unable to conclude that a cellulitis infection with a subsequent hospitalization and surgery had resulted within 15 minutes to 4 hours of a work incident. The cellulitis, the review officer stated, had resulted from causes unrelated to the worker's employment.

Issue(s)

Did the worker's right knee cellulitis arise out of and in the course of his employment on February 20, 2007 or was it due to the nature of that employment?

Jurisdiction

The Workers' Compensation Appeal Tribunal (WCAT) may consider all questions of fact and law arising in an appeal, but is not bound by legal precedent (see section 250(1) of the *Workers Compensation Act* (Act)). WCAT must make its decision on the merits and justice of the case, but in so doing, must apply a policy of the board of directors of the Board that is applicable in the case. WCAT has exclusive jurisdiction to inquire into, hear and determine all those matters and questions of fact, law and discretion arising or required to be determined in an appeal before it (section 254 of the Act).

This is an appeal by way of rehearing, rather than a hearing *de novo* or an appeal on the record. WCAT has jurisdiction to consider new evidence, and to substitute its own decision for the decision under appeal.

Background and Evidence

On February 20, 2007 the worker was employed as a marine surveyor and was in the course of inspecting a boat motor. On that same date he reported to the emergency department of a local hospital where it was reported that he had twisted his right knee.

At the hospital he was attended by an internal medicine specialist who noted that the worker had pain in his right leg around the knee which had commenced fairly abruptly. The physician noted there was no obvious injury except perhaps a strain, as the worker was crawling around a boat. It was noted that the worker had a minor abrasion to the right knee area a week previously with a dried-up scab over the spot. By the evening of February 20, 2007, the physician reported the worker's leg was very painful and he had sweats and chills. He was found to have a high fever, was admitted to hospital and started on antibiotics. The physician stated that the worker had presented with cellulitis and recommended continuation of antibiotics and a referral to an orthopaedic surgeon.

Subsequently the diagnosis of cellulitis was confirmed by a whole body bone scan. There was no evidence of active bone or joint infection.

In a March 15, 2007 consultation report an orthopaedic surgeon stated that the worker's infection appeared to be resolving.

The worker made application to the Board on March 16, 2007 and reported that on February 20, 2007 he had bumped and tweaked his right knee on a boat engine. The worker reported immediate pain and stiffness in the knee. By that evening, he reported, he had suffered fever and chills and had been admitted to hospital.

The worker was contacted by a Board officer, who recorded in a March 16, 2007 telephone memorandum that the worker had reported that he had, approximately 15 minutes after bumping his knee on the motor, stiffness and pain. Approximately one-half hour later he could hardly walk and within the hour was shivering uncontrollably. He then reported to the emergency department at a hospital and was immediately admitted and placed on antibiotics.

The worker reported that he had not received an open wound but that a physician felt the infection may have entered through an old scab on the right knee.

On March 23, 2007 the worker's right knee was irrigated and debrided. A March 28, 2007 ultrasound report concluded there was a presence of pre-patellar cellulitis in the worker's right knee.

In a telephone memorandum dated March 29, 2007 a Board officer set out that the worker had been contacted and provided that two weeks prior to February 20, 2007 he had skinned his knee while taking a bag out of a car door. He described bumping his knee against a fender and stated that he had not sought medical attention. The scrape had healed nicely.

The worker explained that on the date of injury he was wearing coveralls over pants. He had bumped his right knee on an engine and within 15 minutes his knee had stiffened. He explained that the engine was in tight quarters. In order to inspect it he

had to crawl over top of it. As he had backed out of the engine space his right knee had bumped on the inboard exhaust manifold riser. There was no blood at the time but he had felt a sharp pain in his knee.

In a further telephone memorandum dated April 11, 2007 a Board officer stated that the worker, while in Mexico between February 4 and 11, 2007, had skinned his knee when dragging his daughter's suitcase out of the trunk of a car. The edge of the suitcase, or the fender or bumper of the vehicle had caused the scrape. The worker reiterated that the scrape was healing nicely prior to the work incident.

A Board medical advisor, in a claim log memo to file dated April 16, 2007, set out that a skin interruption/scratch had pre-existed the work trauma and the work incident was not compatible with a skin interruption. In the Board medical advisor's opinion, four hours for the development of a clinically detectable infection was not biologically plausible. Therefore, there was no reasonable medical causal association to be made between the workplace incident and the worker's need to receive treatment for an infection.

The Board then issued the April 24, 2007 decision and the worker requested a review by the Board's internal Review Division.

The April 27, 2007 consultation report of an orthopaedic surgeon set out that although the worker had an initial scrape outside of work, it was the actual fall and re-injury at work that led to the increased swelling, redness, and obvious infection. In the orthopaedic surgeon's opinion there was an obvious correlation between the incident and the cellulitis.

The worker's submissions to the Review Division are well represented in the body of the Review Division decision and will not be repeated here. With those submissions, the worker provided to the Review Division the October 29, 2007 report of the internal medicine specialist who stated it was reasonable to conclude that an acute infection was underway at the time the worker had presented to hospital. It was not likely, the physician stated, that the worker had symptoms of an aggressive skin infection for days or weeks prior to his presentation at hospital. Medical assessments provided that the worker had an aggressive bacterial infection that could well have come on rapidly and it was quite possible that it came on over the course of several hours as the worker had claimed.

However, the physician noted that the prior scrape in Mexico might have predisposed the worker to subsequent infection. It was conceivable that the worker might have developed his knee infection, even if he had not injured his knee. The physician could not independently verify that the knee was of normal appearance or that the worker was asymptomatic prior to his work on February 20, 2007. If this were true, the physician stated, it would be most plausible to conclude that something happened in the hours before he presented to hospital to cause his infection to erupt. In summary, the

physician stated, that if there were no knee infection or injury of some significance prior to the work injury in question, the physician would conclude that the workplace incident was the responsible triggering factor for the subsequent, aggressive infection.

The Review Division then released the December 13, 2007 decision which the worker subsequently appealed to WCAT. The review officer, in that decision, noted that the histories provided by the worker were inconsistent with the mechanism of injury. The review officer concluded uncertainty led to the workers' speculation that he had struck his right knee on February 20, 2007. At the emergency department of the hospital no obvious injury save for a strain was noted. The review officer also stated that the worker's description of injury was at odds with that related by the orthopaedic surgeon in the consultation report dated April 27, 2007. Based on the inconsistencies regarding the nature of the events on February 20, 2007, the review officer was not persuaded that the evidence supported a relationship between the cellulitis and an incident on February 20, 2007.

An oral hearing was held on July 2, 2008. The worker attended and was represented by a worker's advisor in the province's Compensation Advisory Services.

At the hearing an undated, unsigned witness statement, provided to the panel prior to the oral hearing, was accepted as exhibit #1. That statement provided that on the afternoon of February 20, 2007, the worker had been witnessed as limping. When asked what had happened, the worker had informed the witness that he had injured his knee.

Also accepted as exhibit #2 was the July 1, 2008 signed statement of the worker's spouse. The worker's spouse recalled the events of February 20, 2007 and confirmed that the worker had been in good health prior to banging his knee on February 20, 2007. The spouse stated that she was not even aware the worker had skinned his knee in Mexico until it was referred to at the hospital. In her opinion, it was not a noteworthy event and if there had been an infection, she stated there would have been some signs the scrape would not have been fully healed. To her recollection, all that remained on February 20, 2007 was a small bit of scab about one-quarter inch long.

The worker's spouse also recalled an incident approximately 11 years prior when the worker had suffered a rapid infection with similar symptoms.

At the hearing the worker was led through his oral testimony by way of a series of questions from the worker's advisor.

He explained that he had been employed as a marine surveyor since 1979. His duties included inspecting yachts to determine a pre-purchase condition. Also, he worked for underwriters providing claims and insurance inspections.

The worker explained that approximately ten years ago, he had skinned his knuckle while working on plumbing and had an onset of a severe infection. He explained that at that time there was no serious wound and that he had not initially required medical attention. However, the infection had progressed quickly, culminating in a loss of consciousness.

The worker described that between February 5 and 11, 2007 he had been on a family vacation in Mexico. Near the end of that trip he had rented a car and had skinned his knee while pulling luggage out of the trunk. Although he could not recall the exact date of that incident, he felt it was several days prior to his return to Canada. He stated it was not a significant incident. The knee was skinned but there had been no blood. The worker had placed a bandage on the scrape and carried on. He recalled nothing abnormal in his healing and stated that the site soon formed a scab. He denied anything unhealthy with his knee upon his return to work on February 12, 2007. He then worked from February 12, 2007, through February 20, 2007 performing his normal work activities. During that timeframe, he stated he conducted at least five surveys and one to two ongoing insurance claims. Those duties required him to be in and around boats. He stated his knee gave him no problems.

On February 20, 2007 the worker completed a survey in the morning. Towards the end of the day he initiated another. That survey required him to inspect an outboard engine. The worker described it as a "nightmare" for inspection. In order to carry out the inspection he had to lay prone across the engine with his head towards the left side of the boat. He lay across it and placed all of his weight on top of the engine. There was no fulcrum for his knees and his legs were straight out. His stomach and chest were placed over top of the motor and the worker used his hand for support. Once the inspection was completed, over the course of approximately two minutes, he stated that in order to exit from the inspection he had to push off with his hand. His weight was on the top of the engine. He stated that he pushed backwards with his legs. His knees pushed against the motor. He had to stay low and use his arms and elbows in order to support his weight. He described the process as "wiggling backwards". The worker stated that he was not sliding on top of the motor but was transferring his body weight. During that transfer, his knees took the brunt of his body weight. The worker was not aware that while wiggling off the top of the motor, he had hit one particular motor clamp with his knee, but stated that he had definitely contacted with something sharp. He felt an immediate sharp pain in his right knee when he was still on the motor top, better than halfway off the motor.

The worker demonstrated, with the use of a hearing room table, the motions required to wiggle off of the motor. He demonstrated that his right leg would have been on an almost 90 degree angle when he was pushing down on both knees against the surface in order to extricate himself from this position.

The worker explained that the engine was fairly warm as the motor had idled while it had been moved to a marine elevator for the inspection. The engine was warm to the touch, but he could not recall any obvious oil spills or puddling of oil on the motor. However, he explained, it took a great deal of exertion to get on and off of the motor top. During the worker's inspection, he had worn a pair of khaki pants and a shirt underneath coveralls, which was his usual practice. He stated that he usually laundered his coveralls over two weeks' use, and could not recall anything unusual about the cleanliness of the coveralls at that time.

After suffering a considerable flash of pain when wiggling off the motor, the worker stated that within 15 minutes his knee was achy and extremely painful. He stated that the pain was in the back of his knee and on the kneecap. At that point he had met a marine mechanic (exhibit #1) after walking approximately 300 yards on the dock. He recalled that the mechanic had asked why he was limping. He responded that he thought he had injured his knee.

When asked why the worker had not provided that information to Board officers prior to the adjudication of his claim, he stated he did not think it was necessary. However, the Review Division decision had questioned his credibility and he now thought it was necessary to report the meeting.

By the time the worker reached the end of the dock it was his intention to return home to his office to complete paperwork. By that point he was limping and in pain. He stated it was even difficult to get into his car which he had to drive 20 to 25 minutes to his office. The worker stated that he had problems depressing the gas petal with his right foot. He was breaking with his left foot. His pain continued to escalate to the point of fevers and chills. The worker stated his knee at that point had started to swell up. The swelling was on the whole knee, on the sides and at the top of the knee cap. He stated that there was also a great deal of uniform redness on the knee. He was not sure if the area of the scrape from his vacation was more swollen or red and stated he did not think that it stood out from the rest of the knee.

At that point the worker felt that he had injured his knee and it was apparent that he needed to attend emergency for treatment. His wife drove him to the emergency department and he had to use a wheel chair to enter. His knee had worsened and he was in intense pain which came on in waves.

When first assessed the worker documented that he had "twisted" his knee. He stated that this description was based on the mechanism required to get off the motor. At that point he thought he had twisted his knee or injured his knee cap. The examining physician thought that the worker's problem was not a knee injury but an infection.

Subsequently, the worker did not respond well to antibiotics and there was difficulty in trying to identify the infection. He recalled that he was examined by a physician familiar

with common infections in Mexico. The physician had informed the worker that his infection was not similar to those found in Mexico. The worker recalled that the specialist could not identify a specific culture responsible for the infection. Blood tests could not confirm the bacteria that had caused the infection.

The worker stated he felt that his infection was related to his work as he had felt an immediate onset of pain during the inspection, followed by sharp pain and then the need to seek immediate medical attention.

He recalled no tear in the material of his coveralls and there also was no blood on his pants.

Prior to February 20, 2007, the worker stated that the scrape from Mexico had formed a scab and portions of that scab had fallen off. A scab of approximately a quarter of an inch long remained.

When questioned why the orthopaedic surgeon had described a fall as a mechanism of injury, the worker stated that this could be attributed to a misunderstanding. He noted that at the time of the consultation, the orthopaedic surgeon had not taken notes.

In submission, the worker's advisor, on behalf of the worker, saw the basic issue to be whether the infection was related to a knee injury on February 20, 2007.

The advisor referenced policy item #13.10 of the *Rehabilitation Services and Claims Manual, Volume II* (RSCM II) and stated a traumatic injury had triggered an external or internal process, causing an infection.

The review officer had denied the worker's claim on the basis there had been variable descriptions of the mechanism of injury and he had doubted whether a rapid onset of symptoms could be related to the injury.

In those assumptions, the review officer had provided a medical opinion which did not consider the actual circumstances of the worker's injury.

The worker's oral testimony, the worker's advisor stated, left no doubt about the fact that the mechanism of injury had required complex movements and required motions of the worker's legs, consistent with the injury. The review officer had erred in providing significant weight to minor inconsistencies in the medical transcriptions. It was notable that the medical evidence of the treating physicians including that of the specialists, was that the rapid development of an infection was plausible.

There was also a temporal correlation. The worker's evidence was credible with respect to the condition of the existing scrape on his knee acquired while he was on

vacation. In fact, the Board had placed too much emphasis on that scrape and had ignored the mechanism of injury. The worker's advisor's stated, that it was reasonable to conclude the infection had occurred over a short timeframe.

The testimony of the worker's spouse (exhibit #2) and the e-mail transcriptions provided to the Review Division both confirmed that the worker had been asymptomatic prior to February 20, 2007. Given the history of the claim, the worker's advisor stated, the mechanism of injury of February 20, 2007 had been a triggering factor in the development of the infection. The worker's oral testimony had also clarified the facts and pointed to the review officer's error in casting doubt on the medical possibility of the cause of the infection.

In summary, the worker's advisor stated that there was overwhelming evidence that there was a causative connection between the worker's employment and the infection as endorsed by the medical opinions. The review officer had erred in the interpretation of those medical findings and the worker's advisor stated that there was no basis for an assumption that the worker had acquired an infection in Mexico.

The evidence was not equally balanced and in fact the worker's advisor stated, there was confirmation that the worker's infection had arisen out of and in the course of an injury which had occurred on February 20, 2007.

Reasons and Findings

I accept the worker's oral hearing testimony that a right knee infection did not exist prior to February 20, 2007. The oral hearing testimony of the worker has been corroborated by his spouse (exhibit #2) and the e-mail transmission provided to the Review Division. The worker's evidence with respect to a pre-existing right knee condition prior to February 20, 2007 has been consistent throughout the claim's history.

There is also no significant discrepancy in the worker's evidence with respect to a mechanism of injury. A discrepancy lies in the orthopaedic surgeon's interpretation of the worker's history. However, it does not appear that the worker openly provided a differing description of his work activity on February 20, 2007. I find his evidence in this regard, including his oral hearing testimony, has not been speculative or inconsistent. Although the worker was not able to definitively confirm the area of the motor he had bumped his knee against, it would not be unusual given that he was flat on his stomach at the time and was not able to see behind him. Although he as able to provide greater detail of the mechanism of injury at the oral hearing, his contemporary evidence was that he had injured his knee "crawling around a boat" in a confined space. Descriptions to Board officer's (March 16, 2007, March 29, 2007 and April 11, 2007) as well as his submissions to the Review Division were remarkably similar. The inconsistency found in the consultation report of the orthopaedic surgeon does not reflect a pattern but an

anomaly. The worker's description of the mechanism of injury has generally not varied from that provided at the oral hearing.

I find the evidence that the worker had a pre-existing scrape is insufficient to establish that the cellulitis arose spontaneously as a result of an underlying condition. The worker was capable of a full return to work upon return from his vacation and there is no reliable evidence the pre-existing scrape was a portal site for the subsequent infection.

Having established these facts, I find the October 29, 2007 opinion of the internal medicine specialist persuasive and accept that the mechanism of injury as described by the worker was the "responsible triggering factor" for the subsequent infection.

Although the Board medical advisor (claim log memo April 16, 2007) opined that the development of the clinically detectable infection was not biologically plausible, this is a view contrary to those of the treating physicians, most notably to that of the internal medicine specialist.

There is sufficient evidence to satisfy me that the worker had a rapid onset of symptoms temporal to the work place incident of February 20, 2007. I therefore find that it is more probable than not that the right knee cellulitis arose out of and in the course of the worker's employment on February 20, 2007.

Conclusion

For the foregoing reasons the December 13, 2007 Review Division decision is varied. I find that the worker's right knee cellulitis arose out of and in the course of his employment on February 20, 2007. The file is returned to the Board to determine the worker's entitlement to healthcare and wage loss benefits.

In accordance with section 7 of the *Workers Compensation Act Appeal Regulation,* the worker is entitled to be reimbursed for his wage loss in order to attend the July 2, 2008 oral hearing. If the worker incurred expenses for providing the Review Decision with the October 29, 2007 report from the internal medicine specialist, and this expense has not been reimbursed, I order the Board to reimburse the worker for this expense in accordance with the Board's tariff.

No further expenses were requested and finding none I make no further order in that regard.

David A. Cox
Vice Chair

DAC/hb/pme