The worker suffered a compensable injury in March 1988 when a nail punctured his left wrist. In August 1988, he underwent left elbow surgery for decompression of the ulnar nerve. In December 1988, the Board discontinued benefits on the basis that the worker had recovered from the wrist injury. The worker appealed a decision of the Hearings Officer denying further entitlement for continuing elbow disability.

The Panel accepted medical evidence that only the sensory part of the ulnar nerve could have been injured in the accident and that an injury at that level could not have caused damage to the nerve at the elbow. Therefore, the Panel concluded that the elbow condition was not a direct result of the wrist injury.

However, on the evidence, the Panel found that the surgery was performed to relieve the compensable wrist condition. This surgery was not necessary and the Panel had no explanation as to why it was performed to relieve the wrist problems. Nevertheless, it was performed to relieve wrist symptoms and it did cause the subsequent disability. The continuing elbow condition was a consequence of treatment for the compensable wrist condition. Accordingly, the worker was entitled to ongoing benefits for the elbow condition.

The appeal was allowed. The Panel directed that the employer be relieved of the costs resulting from this decision. [15 pages]
This appeal was heard in Toronto on May 2, 1991, by a Tribunal Panel consisting of:

J.G. Bigras: Vice-Chair,
P.A. Barbeau: Member representative of employers,
D.B. Beattie: Member representative of workers.

THE APPEAL PROCEEDINGS

The worker is appealing the decision of Hearings Officer, V.W. Ferguson, dated September 5, 1990. The decision denied the worker entitlement to compensation benefits subsequent to December 5, 1988, for an elbow disability.

The worker attended and was represented by E. Batten, national representative, Energy and Chemical Workers' Union. The employer was represented by C. Frail of E-Z Comp, consultants.

THE EVIDENCE

The Panel had for its consideration the Case Description prepared by the Tribunal Counsel Office (TCO). Also made available to the parties and the Panel were two Addenda containing additional information entered by TCO and the parties. The worker gave oral evidence.

Post-hearing, the worker's medical file was transmitted to Dr. T.A. Gray, chief of the Division of Neurology at the University of Toronto's Faculty of Medicine. The Panel directed the Tribunal's Medical Liaison Office to place questions before Dr. Gray on the medical relationship between the worker's accident of March 11, 1988, and elbow condition at issue in this case. Dr. Gray examined the worker and his report to the Tribunal was dated February 28, 1992. Ms. E. Zarour's submission on behalf of the employer was dated April 20, 1992, and Mr. Batten's final submission was received April 21, 1992.

THE NATURE OF THE CASE

The worker sustained a work-related puncture injury to his left wrist on March 11, 1988. He laid off work and received medical treatment.

On August 24, 1988, the worker underwent surgery for relief of compression to the left ulnar nerve at the elbow and continued to receive compensation benefits for his wrist injury. However, the worker's benefits were terminated on December 5, 1988, when it was found that the continuing disability resulted from the elbow condition which was not related to the accident of March 11, 1988.
The issue, therefore, is whether or not the worker's condition subsequent to December 5, 1988, was causally related to the accident to the worker's left wrist on March 11, 1988.

THE PANEL'S REASONS

(i) Background

The worker was a 25-year-old construction labourer. On March 11, 1988, the worker was injured as he put his left arm in front of him as protection from a falling 4-by-4 piece of wood. A four-inch nail pierced his left wrist.

The worker's medical record shows that he received initial treatment at the North York Branson Hospital. X-rays showed no bony or soft tissue abnormalities. The worker was complaining of numbness and tingling in the fourth and fifth fingers and a lack of feeling in his left hand. He was under the care of family physician, Dr. S. Gore.

On August 24, 1988, the worker underwent surgery for decompression of the ulnar nerve in the left elbow. The surgery was a transposition of the ulnar nerve from the back to the front of the elbow.

The worker returned to work briefly as a construction site flagman in September 1988, but states that he had to leave work due to pain in the left arm. He also returned to work briefly in a signalman capacity in November 1989, but states that he could not continue. The worker now claims that his left arm is completely disabled.

The Board terminated compensation benefits on December 5, 1988. It was found at that time that the worker had completely recovered from the puncture injury to the left wrist and that the continuing disability was due to a left elbow condition unrelated to his accident of March 11, 1988.

(ii) The medical evidence

In the present case, the first symptoms of a continuing medical problem reported by Dr. Gore in the Doctor's First Report of April 30, 1988, was decreased sensitivity (hypoesthesia) of the fourth and fifth fingers of the left hand plus an unpleasant sensation (dysesthesia) when the medial aspect of the left wrist was scratched or rubbed.

On June 21, 1988, tests were conducted by neurologist, Dr. F. Dindar, who reported as follows:

A detailed left ulnar nerve study including ulnar sensory conduction from the little finger to above elbow was normal. Left median nerve study was also normal.

On clinical examination this man has features of an ulnar nerve lesion affecting predominantly the sensory fibres. The normal sensory and nerve conduction would indicate that only a small number of sensory fibres have been affected. As he has a fairly strongly positive Tinel's
sign in the upper forearm this is likely to be the site of the lesion. He is quite muscular and it is possible that with increased muscular activity there may be compression of the ulnar nerve by the proximal end of the flexor carpi ulnaris muscle. If he is subjected to surgery he may be a candidate for simple decompression of the cubital tunnel. Some of these patients may have a small band a few cm. distal to the cubital tunnel.

On August 24, 1988, had surgeon Dr. G.D. Millman, performed a "decompression and transposition of the ulnar nerve". According to a review by Board surgeon, Dr. E.J. Macfarlane, dated February 26, 1990, the operation involved transposing the ulnar nerve from behind the medial epicondyle to the front of the medial epicondyle. The surgery took place following medical events described as follows in a letter to the Board dated January 25, 1990:

This gentleman was first seen by me on 17 March 1988 complaining of decreased sensation along the ulnar border of his left hand, distal to a puncture wound just distal to the ulnar styloid, sustained when a 4 inch spike was driven through his hand on 11 March 1988.

Examination at that time confirmed decreased sensation along the little finger but no ulnar motor deficit. It was felt that this was a partial injury, and that spontaneous improvement would proceed. He was therefore reassured, and when reassessed on 8 April 1988, sensation of the little finger appeared normal, although there was some tingling still noted on percussion of the puncture wound. In addition it now appeared that he was having some symptoms of tingling proximal to the injury wound.

The patient was next seen on 21 June 1988 complaining that the little finger was now tingling constantly and that his whole hand was sometimes numb and very sweaty. Although sensation and strength appeared normal at this time he was sent for nerve conduction studies of the ulnar nerve. This study of 21 June 1988 revealed a "normal left ulnar nerve study", however it was the feeling of the neurologist that "on clinical examination, this man has features of an ulnar lesion affecting predominantly sensory fibres.

The normal sensory and nerve conduction indicated that only a small number of sensory fibres have been affected. As he has a fairly strong positive Tinel sign in the upper forearm, this is likely to be the site of the lesion. He is quite muscular and it is possible that with increased muscular activity there may be compression of the ulnar nerve at the proximal end of the flexor carpi ulnaris muscle". These findings, along with the possibility of surgery was discussed with the patient, but he decided that he would like to think about it.
He returned on 12 July 1988, having decided to go ahead with surgery. The surgery was discussed, and he underwent decompression of the ulnar nerve at the elbow on 24 August 1988.

According to Dr. Millman's report of January 6, 1989, when seen on September 20, 1988, the worker's left hand appeared normal, and the elbow had almost returned to normal. However, on March 29, 1989, the worker was reporting to the Board that the elbow condition was worse and that Dr. Millman had advised him that he would require further surgery.

On April 26, 1989, the worker underwent electromyographic examination by Dr. B. Gardner-Maher. Following is the relevant part of her examination report:

Presently, the patient is complaining of pins and needles and numbness from the left mid-forearm in the ulnar aspect to two inches above the scar. These paresthesiae are experienced if he passes his right hand over that area. He does not experience any pain except if he leans on his left elbow. The patient denies any paresthesiae if he does not touch his left forearm. The patient claims that when he drinks the paresthesiae are very bad. The strength in his left hand has markedly improved, in that he can now do push-ups and do some lifting. There is however, still a very slight weakness.

His neurological enquiry is otherwise negative except for weakness of the left foot and the extension of the left toes for the past one to one and a half months. This came on suddenly but has been improving. There is also an associated numbness of the left big toe and the dorsum of the left foot. The numbness is now intermittent.

On examination, he has a good range of painless neck movements and there is no craniocervical bruit. His cranial nerves are intact. There is a slight weakness of the left hypothenar and interossei muscles. Upper and lower limb strength is otherwise normal except of a mild weakness of the left dorsiflexors of the left foot and the extensors of the left toes. Reflexes are present and symmetrical. Plantar responses are downgoing. Sensory examination is normal to all modalities. Tone and co-ordination as well as gait and tandem gait are normal.

The electromyographic findings show occasional denervation, indicating involvement of the left ulnar nerve. It is difficult to say if these occasional potentials are representative of the old ulnar nerve injury or a new one. The patient was advised to avoid leaning his left elbow or left forearm on tables or armrests. Should the symptoms progress or fail to
subside, electromyography and nerve conduction studies could be repeated in a few months time. There is also evidence of a mild left peroneal nerve palsy and the patient was advised to have nerve conduction studies done, should the symptoms not continue to improve as they are doing presently. He was also advised to avoid crossing his left leg over the right one.

(iii) The reasoning

As stated earlier, the issue in the present case is whether or not the worker's left arm injury is causally related to the compensable accident of March 11, 1988. The determination of a causal relationship between an injury and an accident requires the examination of the evidence pertaining to elements connecting the accident and the injury.

In the present case, two important elements in such an inquiry strongly support a connection between the worker's accident and his subsequent condition related to his left arm. First, it is clear that the worker did not have any pre-existing condition involving his left upper limb. At the time of his injury, the worker was a 26-year-old construction worker with no apparent health problems, and, more specifically, with no prior history of any problems with his left arm, according to his family physician, Dr. Gore, who searched his records for the benefit of a Board investigator in 1990.

The historical sequence of events in this case is also supportive of a causal connection between the worker's accident and the disabling condition involving the left arm, which persisted subsequent to December 5, 1988. Setting aside the medical opinions which we will analyze later, we note that the worker sustained a serious puncture injury to the left wrist on March 11, 1988. He immediately reported numbness and tingling in the palm of the hand and the fourth and fifth fingers. As the symptoms persisted and appeared to become more severe, it was decided to perform nerve transposition surgery on August 24, 1988. Although there was temporary relief reported by the surgeon, the worker continued to complain and, in fact, reported a worsening condition subsequent to the surgery. The worker continued to report symptoms of numbness and tingling in the fingers and the hand, with added pain to the surgical scar and to the elbow where the nerve transposition took place. The sequence of events in this case is one to which consideration must be given in weighing the evidence at hand pertaining to the worker's entitlement to compensation benefits.

The issue therefore revolves around the question of whether or not the medical evidence establishes, on the balance of probabilities, that the elbow condition results from the worker's compensable injury. In examining this issue, it must be kept in mind that a causal link between an accident injury and a subsequent disabling condition can take two forms. First, a disability shown to arise as a direct result of an accidental injury is compensable. This is to say that, in the present case, if it were shown that the elbow condition was caused by the puncture wound to the wrist, the resulting disability would be compensable. Second, it must also be kept in mind that a disability resulting from an injury, although not caused by the accidental injury but from its sequelae, is also compensable. In the present case, should it be shown that the elbow condition resulted from the worker's wrist
problem or from the treatment given for the puncture injury to the worker's left wrist, the disability caused by the surgery would be compensable.

While it is not difficult to visualize the issue of the compensability of a disability resulting directly of a work-related injury as we will analyze this case in the first instance. However, the issue of an indirect link between an injury and a subsequent disability requires a second look at the evidence from a perspective of the treatment received.

Our examination of these two issues follows.

(a) Did the left arm condition result from the wrist injury?

The medical history of the worker's case shows that the original injury was sustained to the left wrist. The worker had some numbness to the palm of the hand and the two extreme digits and, as explained by the treating physicians, this shows the possibility that the ulnar nerve was damaged. Nerve conduction tests revealed the possibility of problems involving the ulnar nerve higher in the worker's arm and surgery was performed to release the ulnar nerve from its normal location in the cubital tunnel in the back of the elbow, and transpose it to the front of the elbow. Evidence that we accept, including the worker's oral evidence, his complaints found in the record, and the subsequent medical reports, show that the tingling and numbness in the hand may have subsided, although not completely, but that there was increased pain from a point in the mid-forearm to the middle of the upper arm, halfway between the elbow and the shoulder.

The worker's family physician, Dr. S. Gore, states that the worker's wrist and elbow problems are inter-related and were originally caused by the accident of March 11, 1988. Dr. Gore explained in a memo dated October 16, 1989:


He subsequently required an ulnar nerve transfer.

He continues to suffer pain and altered sensation. He may require further surgery which, at this time, may not be successful. There is a strong possibility of permanent disability.

At the Panel's request, the worker was examined by Dr. T.A. Gray, a neurologist, who has been appointed under section 86h of the pre-1990 Act, as a medical expert who may be called to assist the Tribunal in making determinations pertaining to medical issues before it.

In his report dated February 28, 1992, Dr. Gray expressed the opinion that the worker's injury of March 11, 1988, could not have caused the damage to the ulnar nerve at the elbow. Following is Dr. Gray's explanation:

The nerve which may have been involved in the original compensable injury to the left wrist is the sensory part of the same nerve involved in the left elbow surgery of
August 1988. Both the motor and sensory components of the ulnar nerve travel behind the elbow and then the forearm. The ulnar nerve continues into the hand to supply the muscles of the hand. About 2/3 of the way down the forearm, it gives off a sensory branch which extends down to supply the sensation of the lower part of the forearm, the medial and underside of the palm and the fifth finger as well as the adjacent half of the 4th finger. It is a branch of this sensory nerve which was injured in the original compensable injury to the left wrist in March of 1988. As far as can be ascertained from the notes and the various consultants' descriptions, there was no damage to the motor part of the nerve. There is no way in which an injury at this level could have damaged the nerve higher up in the forearm or at the elbow.

Dr. Gray gives as an alternate reason for the worker's complaints at the time of his examination that there could have been a compression or entrapment of the ulnar nerve at or distal to the elbow. He states that this is common to persons who have diabetes, patients who drink heavily or those who impose repeated trauma to the elbow (leaning, flexing or heavy work). He notes that Dr. Gardner-Maher had found symptoms of nerve palsy in the peroneal nerve in the left leg and that this may have been associated with heavy drinking. This later condition is reported to have developed a year after the March 11, 1988, accident.

The Board's Dr. Macfarlane assessed the reports of Dr. Millman and Dr. Gardner-Maher and concluded that there was no evidence that the wrist and elbow conditions were related. Following is Dr. Macfarlane's assessment of the medical situation:

I reviewed this file again briefly for you. In his accident date of March 11, 1988 he had the penetrating injury to the left wrist area. The EMG that was carried out by Dr. Dindar July 21, 1988 suggested that there was compression of the ulnar nerve in the left forearm. You will note that he was talking about the ulnar nerve being compressed by the flexor carpi ulnaris and he thought that this was because the patient had muscular forearms.

We then have the operation note of August 24, 1988 and the operation was done at the left elbow in the ulnar groove. This involved transposing the ulnar nerve from behind the medial epicondyle to in front of the medial epicondyle. This, of course, is not in the area that Dr. Dindar was talking about the ulnar nerve being compressed.

The surgeon saw the patient in post op up until September 20, 1988 and at the time the patient felt his hand was normal and the sensation at the elbow was almost normal. He was cleared to return to work September 26, 1988. If the patient had a normal hand then this would indicate that even if he had had an ulnar nerve lesion at the wrist it had cleared up by that time. We
then have the report from the neurologist April 26, 1989. She records that the patient was complaining of pins and needles and numbness from the left mid-forearm on the ulnar aspect to 2 inches above the scar. I presume this is the scar on the medial aspect of the elbow. The patient was complaining about paresthesia if you stroke this area. She also recorded slight weakness of the left hypothenar and interosseous muscles. This would imply that there was some residual weakness of the left ulnar nerve but it would not be possible to say at what level. You will note that she felt there was (sic) some findings indicating a denervation of the ulnar nerve but she could not say whether this was due to an old nerve injury or a new one. She advised the patient to avoid leaning on his elbow and the reason for that would be unclear since in fact the median nerve had been moved to the front of the elbow and if the patient leaned on his elbow he would not affect it. She also mentions that he should not lean on his left forearm on tables or arm rests which would be difficult to understand as well in view of the fact that the ulnar nerve was on the front as I indicated.

(our emphasis)

From this report it would seem that if the patient does in fact have a residual problem from the ulnar nerve we cannot tell from which level and it would certainly not seem to be very disabling. It would seem to be more of a subjective nature.

Finally, we have a report from the surgeon of January 25, 1990 and he clearly indicates that the patient's elbows problem is not related to the puncture wound at the wrist. He is now talking about an overuse syndrome but due to the muscles in the forearm which of course was what Dr. Dindar was talking about originally and of course which the surgery did not focus on.

In summary, therefore, we do not have any evidence in the two additional reports to support that the elbow ulnar nerve surgery was in any way related to his puncture wound in the left wrist.

The Panel's understanding of the medical experts' explanations of the issue of a direct relationship between the accident injury and the disabling condition during the period at issue - post-surgery condition - is that the puncture injury could only have damaged the sensory branch of the ulnar nerve at the wrist and that this could not have been linked to any injury to the nerve in the cubital tunnel of the elbow. Therefore, given that the surgery was performed to relieve an elbow condition and the subsequent disabling condition appears to result from the elbow surgery, the resulting disability does not result from the wrist injury. (We will examine later the possibility of alternate causes, as stated by Dr. Gray.)
Therefore, on the medical evidence before us, we find that the worker's elbow disability subsequent to December 5, 1988, does not result from the wrist injury of March 11, 1988.

(b) Did the condition result from the sequelae of the compensable injury of March 11, 1988?

As seen earlier, an injured worker is entitled to compensation if his disability results from the sequelae of a compensable injury, or from the treatment of such injury. In the present case, it is our finding that the disabling condition to the worker's arm after the surgery of August 24, 1988, resulted from the surgery undertaken to relieve the symptoms of the accident injury and therefore, that the worker is entitled to compensation benefits.

Our finding in this case is not in accordance with the opinions set out by the medical assessor, Dr. Gray, to whom we referred the issue of causality. The Panel is not satisfied that the medical opinions expressed in this case cover the global issue of causation. It must be noted that, as stated in Decision No. 915 (1986) 7 W.C.A.T.R. 1, medical evidence, like any other evidence, must be weighed on its merits and a determination on an issue must be taken on the balance of probabilities involving all the evidence on the matter at hand.

We have accepted Dr. Gray's opinion that the worker's original injury was to the wrist and, due to the anatomical disposition of the ulnar nerve, it would be difficult to find that the injury to the wrist caused a problem in the cubital tunnel of the worker's elbow. However, Dr. Gray's analysis of the situation, does not address the issues which require determination in the context of the worker's entitlement to compensation benefits for the residual injury. The Panel's concerns in this case revolve around three questions. Why was the surgery undertaken? Was the surgery necessary to relieve the worker's symptoms? Did the surgery resolve the worker's compensable problem? Are there alternative reasons for the worker's elbow condition?

1. Why did Dr. Millman perform surgery?

According to Dr. Millman's own history of the case, he saw the worker on March 17, 1988, following the accident, and on June 26, 1988, when the worker was complaining that "his whole hand would go to sleep". Dr. Millman was of the view that Dr. Dindar's tests of June 21, 1988, showed a possible lesion "at the elbow region" and, as the symptoms persisted, he decided to perform surgery.

It is clear in Dr. Millman's notes, as well as in the worker's complaints to the Board as well as his evidence at the hearing, that the burning sensations, the numbness, while variable in the hand and wrist, did not extend beyond the proximal forearm before the surgery. In fact, there is only one mention of the arm, and that is on the worker's report to the Board dated June 16, 1988, which states that "It is getting worse. There is definitely something wrong. My hand and arm is like I hit a funny bone all the time...".

Therefore, it is our finding that the surgery was undertaken to relieve the worker's wrist - and possibly - forearm condition involving tingling, numbness. There are no suggestions in the worker's medical file prior to the
surgery that the symptoms which required correction had any cause other than his puncture injury of March 11, 1988. Therefore, it is our finding that the reason for the surgery of August 24, 1988, was entirely due to complaints resulting from the injury of March 11, 1988.

As we make our finding in this case, we are aware of Dr. Millman's remark, in his letter to the Board dated January 25, 1990, states that he discussed the etiology of the worker's lesion and that "his elbow condition may not have been the direct result of his puncture wound, and it is usually a feature of an overuse syndrome, and may be related to his work in any way". We note that this was said nearly two years after the surgery. There were no symptoms of elbow problems when the surgery was performed.

In fact, we note that Dr. Gray states that there may have been other explanations for the worker's nerve lesion in the forearm which was tentatively diagnosed by Dr. Dindar. However, even if we accepted such a theory, it is clear to us that whatever other conditions the worker may have had, they were not symptomatic and the surgery was not undertaken to relieve these conditions, but to relieve the worker's compensable hand and wrist condition.

2. Was the surgery necessary to relieve the compensable

While it is difficult to make a determination in an issue involving medical treatment, it is in the interests of fairness that we must make this determination in the present case. It is based on the balance of probabilities resulting from the evidence before us. We find that the surgical procedure undertaken in this case was not necessary to relieve the symptoms resulting from the worker's accident.

The most relevant element in our present determination is the view of the Board's Chief Surgical Consultant, Dr. E.J. Macfarlane. On January 11, 1990, Dr. Macfarlane, who had assessed the studies by Drs. Dindar and Gardner-Maher as well as the operative report of Dr. Millman, gave the following opinion:

I reviewed this file again briefly for you. In his accident date of March 11, 1988 he had the penetrating injury to the left wrist area. The EMG that was carried out by Dr. Dindar July 21, 1988 suggested that there was compression of the ulnar nerve in the left forearm. You will note that he was talking about the ulnar nerve being compressed by the flexor carpi ulnaris and he thought that this was because the patient had muscular forearms.

We then have the operation note of August 24, 1988 and the operation was done at the left elbow in the ulnar groove. This involved transposing the ulnar nerve from behind the medial epicondyle to in front of the medial epicondyle. This, of course, is not in the area that Dr. Dindar was talking about the ulnar nerve being compressed.

The surgeon saw the patient in post op up until September 20, 1988 and at the time the patient felt his hand was normal and the sensation at the elbow was almost
normal. He was cleared to return to work September 26, 1988. If the patient had a normal hand then this would indicate that even if he had had an ulnar nerve lesion at the wrist it had cleared up by that time. We then have the report from the neurologist April 26, 1989. She records that the patient was complaining of pins and needles and numbness from the left mid-forearm on the ulnar aspect to 2 inches above the scar. I presume this is the scar on the medial aspect of the elbow. The patient was complaining about paresthesia if you stroke this area. She also recorded slight weakness of the left hypothenar and interossei muscles. This would imply that there was some residual weakness of the left ulnar nerve but it would not be possible to say at what level. You will note that she felt there was (sic) some findings indicating a denervation of the ulnar nerve but she could not say whether this was due to an old nerve injury or a new one. She advised the patient to avoid leaning on his elbow and the reason for that would be unclear since in fact the median nerve had been moved to the front of the elbow and if the patient leaned on his elbow he would not affect it. She also mentions that he should not lean on his left forearm on tables or arm rests which would be difficult to understand as well in view of the fact that the ulnar nerve was on the front as I indicated.

From this report it would seem that if the patient does in fact have a residual problem from the ulnar nerve we cannot tell from which level and it would certainly not seem to be very disabling. It would seem to be more of a subjective nature.

Finally, we have a report from the surgeon of January 25, 1990 and he clearly indicates that the patient's elbows problem is not related to the puncture wound at the wrist. He is now talking about an overuse syndrome but due to the muscles in the forearm which of course was what Dr. Dindar was talking about originally and of course which the surgery did not focus on.

In summary, therefore, we do not have any evidence in the two additional reports to support that the elbow ulnar nerve surgery was in any way related to his puncture wound in the left wrist.

The Panel's view of the issue is that, as explained by Dr. Gray, the nerve damage caused by puncture wound in the wrist, could not possibly have caused any damage higher in the arm. The worker was not complaining of any problems in the area where the surgery occurred. Therefore, we have no explanation why the elbow surgery would have been undertaken on August 24, 1988, to relieve the worker's symptoms including his wrist, hand and forearm.
3. Did the surgery cause the subsequent disability?

With all due respect to the medical experts who have expressed opinions in this case, we find that the worker has suffered from a disability affecting his left arm, from below his elbow to a point halfway between the left elbow and his shoulder since his surgery of August 24, 1988. The symptoms involving his left hand, numbness and tingling in the fingers and palm of the hand, also persist albeit with an apparently lesser degree of severity.

We are aware of Dr. Millman's letter to the Board dated January 6, 1989, mentioning that when he had last seen the worker on September 20, 1988, "the hand felt normal and the elbow sensation had almost returned to normal". Recovery, however, was not achieved, as indicated by Dr. Gore's report to the Board dated March 4, 1989, which describes a left arm muscle atrophy and dysthesia of the left forearm. On March 21, 1989, the worker was reporting to the Board that "it" is worse and "Dr. Millman told me I have to have surgery again". The worker had another appointment with Dr. Millman for April 4, 1989, at which time he was referred for further nerve conduction studies by Dr. Gardner-Maher. The symptoms described by Dr. Gardner-Maher include "pins and needles from the left mid-forearm in the ulnar aspect to two inches above the scar". She adds: "These paraesthesiae are experienced if he passes his right arm over the area". This observation by Dr. Gardner-Maher does not allow us to believe that the worker's symptoms in the hand and upper arm had disappeared.

The worker continued to be treated by his family physician who noted paresthesia in the arms, pain in the left elbow. The worker gave evidence of pins and needles in the left arm, numbness and pain when he leans on the arm: we accept his evidence. We cannot agree with Dr. Gray's opinion that the worker exhibits psychogenic pain magnification of his sensory complaints: the worker's complaints directly refer to two regions, the left hand and wrist where he sustained a puncture injury on March 11, 1988, and the left elbow area where surgery was performed to relieve the symptoms of the wrist injury. There is no psychiatric or psychological evidence showing that the worker was consciously or subconsciously magnifying his symptoms.

4. Are there alternative causes for the worker's condition?

As stated earlier, the surgery was undertaken to relieve the worker's injury-related symptoms. We have found that it was unnecessary in that respect, that it did not relieve the injury-related symptoms, and gave rise to a greater disability involving the worker's elbow area. However, Dr. Gray mentions the possibility that there may have been alternative causes for the nerve lesion in the forearm for which the surgery may have relieved. Should it be shown that there was a separate, non-compensable, condition requiring elbow surgery we would have to consider the apportionment of the residual disability to the compensable condition (for the hand and wrist) and the non-compensable condition (for the elbow).

Dr. Gray mentions that the worker's heavy drinking, heavy work, or even a nerve palsy tentatively diagnosed a year later in his legs, could have caused the ulnar nerve compression for which the transposition could have been necessary. Notwithstanding the worker's trouble with the law due to impaired
driving, as seen in the record, and his own admission that he drinks about 15 pints of beer a week, there is no evidence of health damage due to drinking.

The overuse syndrome theory as expressed by Drs. Millman and Gray is not probable in view of the absence of any history of complaints involving the elbow, and the fact that the elbow symptoms which had never appeared in the past would have developed during the post-accident period after the worker ceased any physical activity due to the accident.

Dr. Gray also suggests that there may be some nerve palsy more noticeable when the worker was drinking as stated by Dr. Gardner-Maher in her report of April 26, 1989. The worker denies he ever mentioned such a situation, stating that it was suggested by Dr. Gardner-Maher during his examination but that he did not think this was the case. In any event, such a situation would not affect the compensability, as it would simply reveal an underlying condition aggravating a compensable condition. We also note that Dr. Gray, who links the increased paraesthesia to nerve palsy in the worker's leg noted by Dr. Gardner-Maher, admits that this link is remote since the nerve palsy which she tentatively diagnosed has apparently developed half a year after the surgery, a year after the worker's compensable accident.

We find that there is no evidence establishing the existence of an alternative reason for the worker's symptoms for which he underwent surgery on August 24, 1988.

(c) The Panel's conclusion

Given our findings that the worker's surgery, although unnecessary to relieve his symptoms, resulted from his accident of March 11, 1988, and that it did not relieve his symptoms, but also caused an additional disability to the worker's left elbow. We conclude that the worker is entitled to compensation for the resulting disability.

(iv) Benefits entitlement

The evidence on file shows that the worker was temporarily partially disabled when his benefits were terminated on December 5, 1988. Family physician, Dr. Gore, never stopped sending reports and memos to the Board to the effect that the worker had problems with his left elbow disabling from work. We find that the worker was partially disabled.

A worker with a temporary partial disability was entitled to full benefits unless he failed to cooperate with Board programs aimed at helping him return to gainful employment or failed to accept suitable employment made available to him [section 40(2)(b) of the pre-1990 Act]. In the present case, the Board had terminated the worker's benefits and no rehabilitative action was undertaken. With respect to suitable employment, the worker had been offered jobs as a flagman: he tried twice to perform this job, but, on both occasions, had to abandon due to his left arm difficulties. The Board was of the view, based on doctors' opinions, that the work made available was suitable. However, due to the general confusion surrounding the medical condition in this case, we accept the worker's evidence, supported by the family doctor's opinion, that he could not carry on this type of employment.
It is, therefore, our finding that the worker did not fail to accept suitable employment. Given that the Board did not offer rehabilitation, and that the work offered is found not to be suitable, we conclude that the worker was entitled to full benefits for a partial disability subsequent to December 5, 1988, ongoing at the time of this decision.

We also direct the Board to have the worker examined in view of determining whether the present condition is permanent. The Board is also directed to take immediate measures to provide the worker the services and benefits to which he is entitled pursuant to section 147 of the Workers' Compensation Act 1990 [section 135 of the pre-1990 Act, as amended].

In view of the iatrogenic nature of the medical condition we direct that the employer be relieved of the costs of the worker's partial disability benefits flowing from this decision.

THE DECISION

The worker's appeal is allowed.

The worker is entitled to full compensation benefits for temporary partial disability, from December 5, 1988, ongoing. The Board is further directed to determine whether the worker's disability is now of a permanent nature.

The worker is also entitled to assistance and benefits pursuant to section 147 of the Workers' Compensation Act 1990.

The employer is relieved of the costs of the partial disability benefits resulting from this decision.

DATED at Toronto, this 30th day of July, 1992.